Alder Hey Children's NHS
NHS Foundation Trust

Reference Number:	FOIAH2425/104 – GIDS
From:	Private Individual
Date:	20 May 2024
Subject:	Gender reassignment and/or transgender guidance and policies

Q1 Please provide:
Gender reassignment and/or transgender guidance and policies relating to staff

A1 Gender reassignment and/or transgender guidance is referenced within several Alder Hey Children's NHS Foundation Trust policies, for example:

the term 'gender reassignment' is referenced in the following Trust policies:

- Respect at Work Policy*
- Equality, Diversity and Human Rights Policy*
- Supporting Sickness and Attendance Policy*
- Flexible Working Policy
- Privacy and Dignity Policy
- Reasonable Adjustments Policy
- Uniform and Dress Code Policy
- Menopause Policy
- Equality Relevance Guidance

the term 'Transgender' is referenced in the following Trust polices:

- Menopause Policy
- Zero tolerance of Racist, Homophobic, Prejudiced or Discriminatory Behaviour
- Organisational Change Policy
- Privacy and Dignity Policy*
- Equality Relevance Guidance
- Safeguarding Adults Policy

As detailed above gender reassignment and/or transgender guidance is referenced within Alder Hey Children's NHS Foundation Trust policies. There are no specific policies relating to gender reassignment.

Q2 Gender reassignment and/or transgender guidance and policies relating to patients including policies on mixed sex /same sex accommodation

A2 The service follows NHS England's policy on puberty suppressing hormones NHS England » Clinical policy: puberty suppressing hormones and gender affirming hormones NHS commissioning » Gender Services Clinical Programme (england.nhs.uk).

See further information at the following link New Specialist Gender Service for Children and Young People Opens - Alder Hey Children's Hospital Trust

Mixed sex/same sex accommodation is also referenced within Trust policies. There are no specific policies relating to mixed sex/same sex accommodation. The acute hospital provides care to children and young people through the majority of single bedrooms. Each

ward has 2 x 4 bed bays which are used either for HDU level care or for the care of babies under 1 – in which case same sex guidance does not apply.

Q3 Related Equality Impact Assessments if separate

A3 Please see the attached.
EIAs are not held for the policies above showing *
The Trust is currently revising an annual plan for systematic review of its policies.

Alder Hey Children's
NHS Foundation Trust

E1 – EQUALITY, DIVERSITY & HUMAN RIGHTS POLICY

Version:	8.3
Name of ratifying committee	Clinical Quality Steering Group
Date ratified:	14/01/2020
Name of originator/author:	Hannah Ainsworth
Name of approval committee:	Workforce and Organisational Development Committee
Date approved	10/12/2019
Name of Executive Sponsor:	Chief Nurse / Director of Human Resources
Key search words:	Equality, diversity, human rights, discrimination, reasonable adjustments, protected groups, protected characteristic, age, disability, gender reassignment, marriage, civil partnership, pregnancy, maternity, sex, sexual orientation
Date issued:	August 2023
Review date:	November 2024 (Extension)

Quick Reference Guide – Equality, Diversity & Human Rights Policy

This policy applies to all Trust employees, contactors and temporary workers, together with any applicants for employment in the Trust, service users and/or any external persons who have a connection with the business of the Trust.

This policy covers all aspects of employment including recruitment and selection, terms and conditions of employment, training and development, and equal opportunities for all staff employed by Alder Hey Children's NHS Foundation Trust.

KEY RESPONSIBILITIES

Managers:

- Lead by example adopting personal standards of behaviour which treat all employees with dignity and respect.
- Deal with staff grievances and patient complaints fairly, appropriately and in a timely manner.
- Fully support and undertake Equality Analysis on all appropriate policies, functions, service changes or reconfigurations and efficiency saving initiatives within the areas they have responsibility for.

Equality and Diversity Manager:

Ensure the Trust meets all statutory requirements to ensure compliance with both the general and specific Equality Duties as defined by the Equality Act 2010.

Employees:

- Have a personal responsibility to carry out their duties and behave at all times in a way which supports equality, recognises diversity and upholds the human rights of service users, colleagues and visitors to the Trust.
- Complete Equality and Diversity basic awareness training within 2 months of commencing employment in the Trust, through Corporate Induction or E-learning.
- Undertake relevant training & development to ensure they keep up to date with equality, diversity and human rights legislation and best practice
- Be aware that unlawful discrimination on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation illegal and could result in legal proceedings.
- Report any unlawful discrimination or suspected discrimination.

Harassment at work in any form is unacceptable and may in certain circumstances be unlawful.

Recruitment, Selection & Promotion

The Trust will ensure that its recruitment, selection and promotion practices provide equal access/opportunities for all persons and are free from unfair or unlawful forms of discrimination.

Reasonable Adjustments

The Equality Act 2010 places a duty on the Trust to make reasonable adjustments to working arrangements, physical features of the premises or services which may place a disabled employee, applicant or service user at a substantial disadvantage (in comparison to non-disabled individuals)

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
8.3	February 2024	Hannah Ainsworth	Current	Extended until Nov 2024
8.2	August 2023	Hannah Ainsworth	Archived	Extended for 6 months
8.1	January 2023	Hannah Ainsworth	Archived	Extended for 6 months
8	January 2020	Hannah Ainsworth	Archived	
7.1	January 2019	Hannah Ainsworth	Archived	Extended for 12 months
7	December 2017	Hannah Ainsworth	Archived	
6	April 2017	Hannah Ainsworth	Archived	Extended for 6 months
5	December 2015	Hannah Ainsworth	Archived	
4	April 2015	Hannah Ainsworth	Archived	Extended for 3 months awaiting changes to Equality Analysis Policy
3	October 2014	Cheryl Farmer, Vivienne Mitchell	Archived	6 month review date set.
2	May 2010	Richard Brown	Archived	
1	December 2005	Pam Chandler-Samuel	Archived	
0	August 1996	Unknown	Archived	

Record of changes made to Equality, Diversity & Human Rights Policy – Version 8.3			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Version and dates updated	Extension

Record of changes made to Equality, Diversity & Human Rights Policy – Version 8.2			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	Extended for 6 months

Record of changes made to Equality, Diversity & Human Rights Policy – Version 8.1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	Extended for 6 months pending review by new EDI lead. Agreed with staff side.

Record of changes made to Equality, Diversity & Human Rights Policy – Version 8			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Various	Various	Cost Improvement Initiatives (CIP) updated to ‘Efficiency Saving’	Updated terminology

Contents

1 Introduction

1.1 The Alder Hey Children's NHS Foundation Trust is committed to creating an inclusive organisation, which seeks to recognise diversity, promote equal opportunities and supports Human Rights in the provision of health services for the communities it serves and in its practice as a leading employer.

1.2 Equality, Diversity and Human Rights are central to the vision, values and long term business development at Alder Hey Children's NHS Foundation Trust and therefore it is important that all three are embedded throughout the organisation into everything we do for patients, parents/ carers and staff.

1.3 In order to do this we endeavour to meet our Public Sector Equality Duties (General Duties) described by the Equality Act 2010, which includes having **due regard** to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

1.4 The Trust is committed to deliver the expected outcomes as identified in the national Equality Delivery System 2 (EDS2) and meet the specific equality duties defined by the Equality Act 2010.

1.5 The Trust is committed to meeting its obligations in regards to the NHS Standard Contract including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

1.6 The Trust respects the different communication and information needs of patients and their families and will seeks ways in which to implement the Accessible Information Standard (AIS).

1.7 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, religion or belief, sex or sexual orientation as defined by the Equality Act 2010, and also members of other inclusion health groups.

1.8 The Trust recognises the impact that effective implementation of a Human Rights Based approach to Healthcare has upon an organisation and is committed to embedding the 'FREDA' principles (Freedom, Respect, Equality, Dignity, Autonomy) into all areas of the Trust. See also United Nations Convention of Human Rights of the Child.

2 Purpose

2.1 This policy describes the actions needed to ensure that the Trust meets its statutory requirements as defined by the Equality Act 2010, and to support the human rights of patients, parents / carers, visitors and employees in the Trust, as defined by the Human Rights Act 1998. Also to ensure that it anticipates

the consequences of its actions on our local communities and ensure that as far as possible, negative consequences are eliminated and opportunities for promoting equality are maximised, wherever possible.

2.2 There are **general** duties that the Trust has to comply with, including having due regard to the need to:

- Eliminate unlawful discrimination and harassment of any person possessing any of the 'protected characteristics' given legal protection under the Equality Act 2010.
- Promote equality of opportunity
- Promote good race relations
- Promote positive attitudes towards disabled people
- Encourage participation in public life by disabled people
- Eliminate discrimination that is unlawful under the Equal Pay Act 1970

2.3 There are also **specific** duties on the Trust to:

- Identify all functions and policies that are relevant to the general duties
- Assess, consult on and monitor the impact of these policies/functions on the general duty
- Publish the results of the assessments, consultations and monitoring of the process

2.4 The Trust endorses the following principles in relation to equality and human rights issues:

- To ensure that the health and wellbeing of all our patients and staff are at the heart of everything we do
- To ensure active engagement with the public, our patients, parents / carers, staff and clinicians
- To work through partnership to achieve mutual benefit
- To respect individuals, and embrace the diversity of our patients and staff
- To work with integrity and honesty

2.5 Alder Hey Children's NHS Foundation Trust fully embraces its responsibilities to be fully inclusive and to challenge and tackle inequalities. It will use a human rights based approach in discharging its functions and will put equality and human rights at the heart of policy, planning, commissioning and delivery of services in order to protect the rights of everyone.

3 Definitions

i. **Equality** is about creating a fairer society in which everyone has the opportunity to fulfil their potential.

ii. **Diversity** is about recognising and valuing difference in its broadest sense.

iii. **Human Rights** are about our basic needs/rights as human beings. They belong to everyone equally and protect an individual's freedom to control their day-to-day life, and participate in all aspects of public life in a fair and equal way.

iv. **Discrimination** is about people being thought of as having different worth or value, being treated differently (less favourably) or given fewer opportunities because they are in possession of one or more protected characteristic(s).

v. **Direct discrimination** treating someone less favorably **because** they have one or more protected characteristics.

vi. **Indirect discrimination** by means of rules, regulations or procedures that may appear to be neutral, but which actually discriminate against certain groups of people.

vii. **Associative discrimination** occurs when someone is treated less favourably because of their **association** with a person(s) in possession of a protected characteristic.

viii. **Perceptive discrimination** occurs when someone is treated less favourably because you ***perceive or assume*** they have a protected characteristic.

ix. **Positive action** is a range of lawful actions that seek to address an imbalance in employment opportunities among specific groups that have previously experienced disadvantage or that are underrepresented in the workplace.

x. **Harassment** is unwanted conduct on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation which has the purpose or effect of either violating a persons' dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment for them.

xi. **Protected characteristics:** The Equality Act 2010 introduced the term **"protected characteristics"** to refer to groups that are protected from discrimination under the provisions of the Equality Act 2010 (see Appendix A). The nine groups are given protection on the grounds of:

- **Age**
- **Disability**
- **Gender reassignment**
- **Marriage or civil partnership**
- **Pregnancy or maternity**
- **Race**
- **Religion or Belief**
- **Sex**
- **Sexual orientation**

xii. **Human Rights:** The Human Rights Act (HRA) was introduced in 1998 and is a comprehensive legal framework which sets out the legal obligations of public authorities in relation to Human Rights. The Act obliges public authorities to treat people in accordance with their Human Rights (as set out in the European Convention of Human Rights).

Human Rights are about the relationship between the state and individuals and are basic standards below which the state must not fall, and in some cases must also protect and fulfil. The Rights in the HRA seek to express key principles and values such as dignity, freedom, democracy and equality.

Human Rights belong to everyone – and are part of what it means to be human.

Human Rights cannot be taken away, but can be limited or restricted in certain cases.

There are three types of Human Rights:

Absolute Rights – which cannot be altered or amended in any way.

Limited Rights - can be limited in specific and finite ways (particularly if the interference is based on a breach of law).

Qualified Rights can be limited in a wider range of circumstances than limited rights, and are the majority of rights in the Human Rights Act. This is because the protection of qualified rights can sometimes affect the rights of others. Often qualified on a 'case to case' basis.

4 Duties

4.1 Management Responsibilities (including Directors, Chiefs, Service Leads, Managers and Supervisors)

All managers and service leads are responsible for implementing this policy in the areas they are responsible for, and for maintaining high standards of equality and human rights practice.

4.2 All mangers must ensure that:

- They lead by example adopting personal standards of behaviour which treat all employees with dignity and respect.
- Staff are aware of this policy and its location
- All staff grievances and patient complaints are dealt with fairly, appropriately and in a timely manner.
- All staff are aware of their individual responsibility for the promotion and practice of equal opportunities and the avoidance of discrimination.
- Patients are made aware of the policy in general patient information.
- They fully support and undertake Equality Analysis on all appropriate policies, functions, service changes or reconfigurations and efficiency saving initiatives within the areas they have responsibility for.

4.3 Equality and Diversity Manager

Has responsibility for ensuring:

- The Trust meets all statutory requirements to ensure compliance with both the general and specific Equality Duties as defined by the Equality Act 2010.
- Support Managers with the delivery of the expected outcomes as identified in the national Equality Delivery System 2 (EDS2), providing reports as required to relevant assurance committees.
- Support for Human Resource team in regards to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)
- Support for staff networks
- Development of the Trust's Equality Objectives and overseeing their implementation, to ensure integration of equality and human rights into mainstream services and corporate functions.
- Completed equality analysis is published and made available when required
- Key stakeholders have access to available support and information on equality and diversity issues.
- Support managers with ways of improving monitoring of processes employed in the Trust where discrimination could potentially be introduced (eg. recruitment and selection or disciplinary and grievance processes) to ensure that no particular protected group(s) are treated less favourably or are overrepresented within any of these processes.
- All equality and diversity training is regularly reviewed and updated to ensure it is fit for purpose.
- Reviewing and updating all equality related policies and authoring new policies as required.
- Production of the equality and human rights section for the Trust's annual report.

4.4 Clinical Quality Steering Group (CQSG) and Workforce and Organisational Development (WOD) Committee

The CQSG and WOD Committee have responsibility for:

- Overseeing the development and implementation of the Trusts equality objectives to ensure integration of equality and diversity into mainstream services, corporate functions and the workforce.
- Undertaking monitoring of progress with all statutory and non-statutory requirements, to provide assurance to relevant governance committees.

4.5 Ratifying Committees and Programme (Transformation) Board

To provide assurance on equality analysis findings, on behalf of the board. This would involve acting as gatekeepers to ensure that a thorough equality analysis has been undertaken when expected, and outcomes discussed and recorded in committee minutes, when necessary.

4.6 Individual staff in the Trust

All Trust employees (including contractors and temporary workers)

- All staff have a personal responsibility to carry out their duties and behave at all times in a way which supports equality, recognises diversity and upholds the human rights of service users, colleagues and visitors to the Trust.

- Undertake relevant training and development to ensure they are kept up to date with equality, diversity and human rights legislation and best practice.

- Be aware that unlawful discrimination on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation illegal and could result in legal proceedings against the Trust and/or against the individual.

- Be aware they have a duty to report any unlawful discrimination or suspected discrimination occurring within the Trust whether by colleagues, service users, visitors or contractors. Help and advice is available from their line manager, Equality and Human Rights Manager, HR business partner/advisor or Trade Union representative (for those members of staff who are members of a Trade Union).

- Enable the Trust to meet its statutory duties by completing Opportunities Monitoring forms when requested.

5 Meeting Equality Requirements

Public Sector Equality Duties:

i. On 5 April 2011 the public sector equality duty (the equality duty) came into force in England, Scotland and Wales. This duty replaced the pre-existing race, disability and gender equality duties.

ii. The public sector equality duty consists of a **general** equality duty, which is set out in section 149 of the Equality Act 2010 itself, and the **specific** duties which came into law on the 10th September 2011.

iii. **In summary, those subject to the general equality duty must, in the exercise of their functions, have due regard to the need to:**

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

- Advance equality of opportunity between people who share a protected characteristic and those who do not.

- Foster good relations between people who share a protected characteristic and those who do not.

iv. **The specific duties require public bodies to:**

- publish information to show their compliance with the Equality Duty, at least annually; and

- Identify and publish equality objectives, at least every four years.

All information must be published in a way which makes it easy for people to access it.

Equality Analysis

i. In order to meet the general duties under the Equality Act all relevant policies, functions, service changes or reconfigurations and efficiency saving initiatives must have an Equality Analysis completed as early as possible during the planning stage. Retrospective Equality Analysis is unlikely to demonstrate **due regard** to the aims of the duty at the point when decisions were being made, and could leave the Trust open to legal challenge.

ii. Equality Analysis is a way of identifying any potential discrimination (direct or indirect) at the earliest possible stages of the planning process and enables action to be taken to eliminate discrimination at the earliest possible opportunity.

iii. The assessment is systematic analysis of the impact of policies, functions, service changes or reconfigurations and efficiency saving initiatives on people from each of the groups given protection from discrimination by the Equality Act 2010.

iv. A thorough assessment should involve the use of all available equality information, and wherever possible the results of engagement with all relevant groups eg. service users, staff, carers and visitors in order to fully understand the impact on individuals from each of the protected groups.

v. In addition to identifying any potential negative impacts, Equality Analysis is also a useful tool in identifying areas of good practice in the Trust.

Duty to make 'reasonable adjustments'

i. The Equality Act 2010 places a duty on the Trust to make reasonable adjustments to working arrangements, physical features of the premises or services which may place a disabled employee, applicant or service user at a substantial disadvantage (in comparison to non-disabled individuals); this is to help disabled people to overcome the practical effects of their disability wherever possible.

ii. The duty does not arise if the Trust is not aware (or could not reasonably be expected to know) that a disabled person has a disability and is therefore likely to be substantially disadvantaged, compared to non-disabled individuals.

iii. Examples of 'reasonable adjustments' could include:

- Flexible working
- Changes to working pattern/shift patterns
- Changes to working environment (structural or physical)
- Redeployment to a more suitable available post in the Trust
- Provision of specialist equipment

This list is not exhaustive, and advice relating to making reasonable adjustments for employees can be obtained from HR Managers / Advisors, Team Prevent Occupational Health Service (x2259).

iv. Where the duty applies, the Trust may be able to justify not making the adjustment on the basis that:

- It was not reasonable or practicable to do so, due to costs, disruption to activities etc. It is important to note, that if using 'cost' as justification for not making a reasonable adjustment, the financial position of the whole organisation is taken into consideration and not an individual area or department.

- The only reasonable adjustment that could have been made would not have made a difference ie. the individual would still remain disadvantaged.

Patients and services

i. Patients, their parents, carers or relatives should be treated with dignity respect and due consideration at all times.

ii. Patients should be afforded healthcare in a consistent and non-discriminatory manner, regardless of their possession of one or more protected characteristic(s).

iii. To ensure equality of access for all our patients, patient access to Trust services, healthcare arrangements or Trust buildings (estate) will be subject to any reasonable adjustments necessary, or appropriate to meet the needs of patients who have a disability.

iv. Religious, belief and cultural needs will be considered when planning a patients' care where necessary.

v. Patients whose first language is not English should be identified at the time of booking their first appointment, and relevant interpreters arranged, patient information will be provided in the appropriate format.

vi. Any patient who considers they have been the victim of discrimination from another service user, carer, relative or a member of staff should be

encouraged to address their issue through the Trusts' **Complaints & Concerns Policy - RM6** (see on DMS). Similarly, any staff member who considers they have been a victim of discrimination should refer to the **Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – RM9** (see on DMS).

vii. All booking and scheduling staff and clinical staff are responsible for making reasonable efforts to obtain equality information from patients, or if appropriate from the relatives or carers at the earliest possible point of patient access to the Trusts services.

Recruitment, selection and promotion of staff

i. The Trust has developed robust processes initiatives to ensure that its recruitment, selection and promotion practices provide equal access/opportunities for all persons and are free from unfair or unlawful forms of discrimination.

ii. No advertisement placed on behalf of the Trust will contain wording which implies there are restrictions upon eligibility to apply for employment in the Trust **except** in instance where a Genuine Occupational Requirement / General Occupational Qualification applies (see Glossary – Appendix A).

iii. Job applicants or employees shall receive no less favourable treatment on the grounds of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation.

iv. The Trust will put in place initiatives to try to develop a workforce that is representative of the local working population.

v. The Trust is a **Level 2 'Disability Confident' employer.**

vi. Regular recruitment and selection training will be made available for managers with responsibility for or involvement in recruitment and selection. All those involved in the recruitment process should ensure that they have received the appropriate training. As a minimum the interview panel Chair must have received training. For further information contact Human Resources.

Training and Development

i. All employees will be given equal opportunity and encouragement to progress and have equal access to learning and development opportunities within the Trust and externally, in order that they achieve their full potential.

ii. All employees of the Trust are required to complete mandatory Equality and Diversity training as part of their corporate induction, within two months of commencing employment in the Trust and every 3 years thereafter.

iii. All employees should have access to a personal development review (PDR) at least annually. New starters in the Trust and existing Trust staff moving to a new post should have access to a PDR within 3 months of commencing in their new role.

iv. Any changes in equality or human rights legislation will be communicated to all staff when required to ensure they are up to date with the latest practice.

v. Reasonable adjustments will be made to ensure that employees with disabilities (including learning disabilities) have the same access to opportunities as those members of staff who do not have a disability.

Service delivery – public and patient involvement

i. The Trust will ensure that its services are non-discriminatory, enabling equality of access and provision and meet the requirements of the general and specific duties of the Equality Act 2010.

ii. The Trust will ensure that priorities are influenced and set by the health needs of our local communities, and health inequalities are narrowed by seeking views of the community and working cohesively with our local commissioners, HealthWatch groups and commissioning support unit to identify and work towards improving health inequalities.

iii. The Trust will actively engage with all our local communities in order to give them the opportunity to help influence and shape the services we offer.

Complaints of unlawful discrimination

i. The Trust will not tolerate any form of unlawful discrimination or harassment and will investigate all complaints of discrimination whether the discriminator is an employee, service user, carer/relative, contractor or volunteer in the Trust.

ii. The Trust will ensure that all complaints are dealt with sensitively, confidentially, thoroughly and in a timely manner in line with the Trust's **Complaints and Concerns Policy – RM6** (see on DMS).

iii. Any member of staff who considers they have been the victim of discrimination from a service user, carer, relative or another member of staff may pursue the matter through the Trust's **Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – RM9** (see on DMS).

iv. Any job applicant, who considers they have been unfairly treated or discriminated against in the operation of the Trust's recruitment and selection procedures should be encouraged to initiate a formal complaint, which will then be dealt with through the Trust's **Complaints and Concerns Policy – RM6** (see on DMS).

Harassment at work

i. The Trust is committed to ensuring that all staff enjoy their working environment and upholds the right of the individual to be treated with consideration, dignity and respect. Harassment at work in any form is unacceptable and may in certain circumstances be unlawful.

ii. The Trust takes its duty to protect staff from harassment seriously, and will take action whether the harassment is from colleagues, service users, carers or visitors. Any member of staff who believes they have been harassed should take action as described in the Trust's **Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – RM9** (see on DMS), or the **Respect at Work Policy – E24** (see on DMS).

Procurement

i. As a major procurement organisation, the Trust will encourage best practice and non-discriminatory principles from within its existing and prospective supplier base. This will form, where appropriate, part of the Trust's formal contractual arrangements and obligations with suppliers.

ii. Private and honorary contractors employed by the Trust in any activity (for example; suppliers of goods or services, researchers) will be required to fully comply with the Trusts Equality and Human Rights Policy when on any of the Trust sites or if conducting business or activity on behalf of the Trust elsewhere.

6 Training

6.1 All staff will be required to complete Equality and Diversity basic awareness training within 2 months of commencing employment in the Trust. This training is available on-line as a workbook on the learning and development website. The training can also be delivered face to face for some departments or individuals who have difficulty accessing on-line training.

7 Monitoring

7.1 The Equality and Diversity Manager will provide an annual Workforce Profile Report to the Workforce and Organisational Development Committee and an annual Patient Profile Report to the Clinical Quality Steering Group.

8 Additional Information

Equality Analysis (Hyperlink)

References

Equality Act 2010
Human Rights in Healthcare – A framework for local action, DH October 2008.
Human Rights in Healthcare – a short introduction, DH October 2008
Mental Capacity Act 2005
NHS Constitution

Associated Documentation (see on DMS).

Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – RM9
Recruitment and Selection Policy – E2
Equality Analysis Policy – E35
Management of Stress at Work Policy – E10
Maternity, Paternity and Adoption Leave Policy – E22
Complaints and Concerns Policy – RM6
Patient Information Leaflets Policy – M13
Respect at Work Policy – E24
Interpreting and Translation Policy – C16
Privacy and Dignity Policy – C47

Appendix A Glossary

Protected characteristics The Equality Act 2010 introduced the term "protected characteristics" to refer to groups that are protected from discrimination under the provisions of the Equality Act 2010. These are listed below:

- **Age**: refers to a person or persons belonging to a particular age group. An age group includes people of the same age and people of a particular range of ages. Where people fall in the same age group they share the protected characteristic of age. Protection only applies to people aged 18 years of age and above.

- **Disability:** as defined by the Equality Act 2010, a person has a disability if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. For the purposes of the Act, these words have the following meanings:
  - **'substantial'** means more than minor or trivial
  - **'long-term'** means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions)
  - **'normal day-to-day activities'** includes everyday things like eating, washing, walking and going shopping

- **Gender reassignment:** This is defined for the purpose of the Act as where a person has proposed, started or completed a process to change his or her sex.

- **Marriage or civil partnership:** This refers to people who have the common characteristic of being married or of being civil partners.

- **Pregnancy and maternity:**
- **Pregnancy** is the condition of being pregnant or expecting a baby.
- **Maternity** refers to the period after the birth, which in the employment context refers to maternity leave. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth. This includes treating a woman unfavourably because she is breastfeeding.

  There is no change to Pregnancy and Maternity under the new act. A woman is protected against discrimination on the grounds of pregnancy and maternity during the period of her pregnancy and any statutory maternity leave to which she is entitled

- **Race:** for the purpose of the Equality Act ‘race’ includes colour, nationality and ethnic or national origins.

  People who have or share characteristics of colour, nationality or ethnic or national origins can be described as belonging to a particular racial group.

- **Religion or Belief:** This covers people with religious or philosophical beliefs. To be considered a religion within the meaning of the Act, it must have a clear structure and belief system. The Act contains the following examples of

'religions': The Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism.

To be considered a philosophical belief for the purposes of the Act, it must be: genuinely held; be a belief and not an opinion or viewpoint; be a belief as to a weighty and substantial aspect of human life and behaviour; attain a certain level of cogency, seriousness, cohesion and importance; and be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others.

- **Sex:** For the purposes of the Act, sex means being a man or a woman.

- **Sexual Orientation:** This is defined in the Act as a person's sexual orientation towards:
  - people of the same sex as him or her (in other words the person is a gay man or a lesbian)
  - people of the opposite sex from him or her (the person is heterosexual)
  - people of both sexes (the person is bisexual)

Positive Action

A term used in the context of UK employment law which, unlike positive discrimination, is generally allowed by legislation: employers can offer disadvantaged groups access to facilities for training and encourage job applications from under-represented groups, but cannot discriminate in selecting candidates for employment or promotion or the terms and conditions on which they are employed.

The Advisory, Conciliation and Arbitration Service (ACAS) provides examples of permitted positive action, including placing advertisements where they are more likely to be seen by the members of a disadvantaged group, encouraging applications from particular protected groups who may be underrepresented in the workforce, employers must ensure that before committing to positive action they have evidence to show that the targeted group is under-represented within the workforce or is likely to have a particular disadvantage in taking up or doing that type of work

Genuine Occupational Requirement (GOR)/Genuine Occupational Qualification (GOQ)

A term used in the context of discrimination legislation relating to sex, race, religion or belief, age and sexual orientation, where an employer is allowed to 'discriminate' in recruitment, transfers, training or dismissal, if the employer can prove that a genuine occupational requirement (GOR) or, in the case of sex or race, genuine occupational qualification (GOQ) exists.

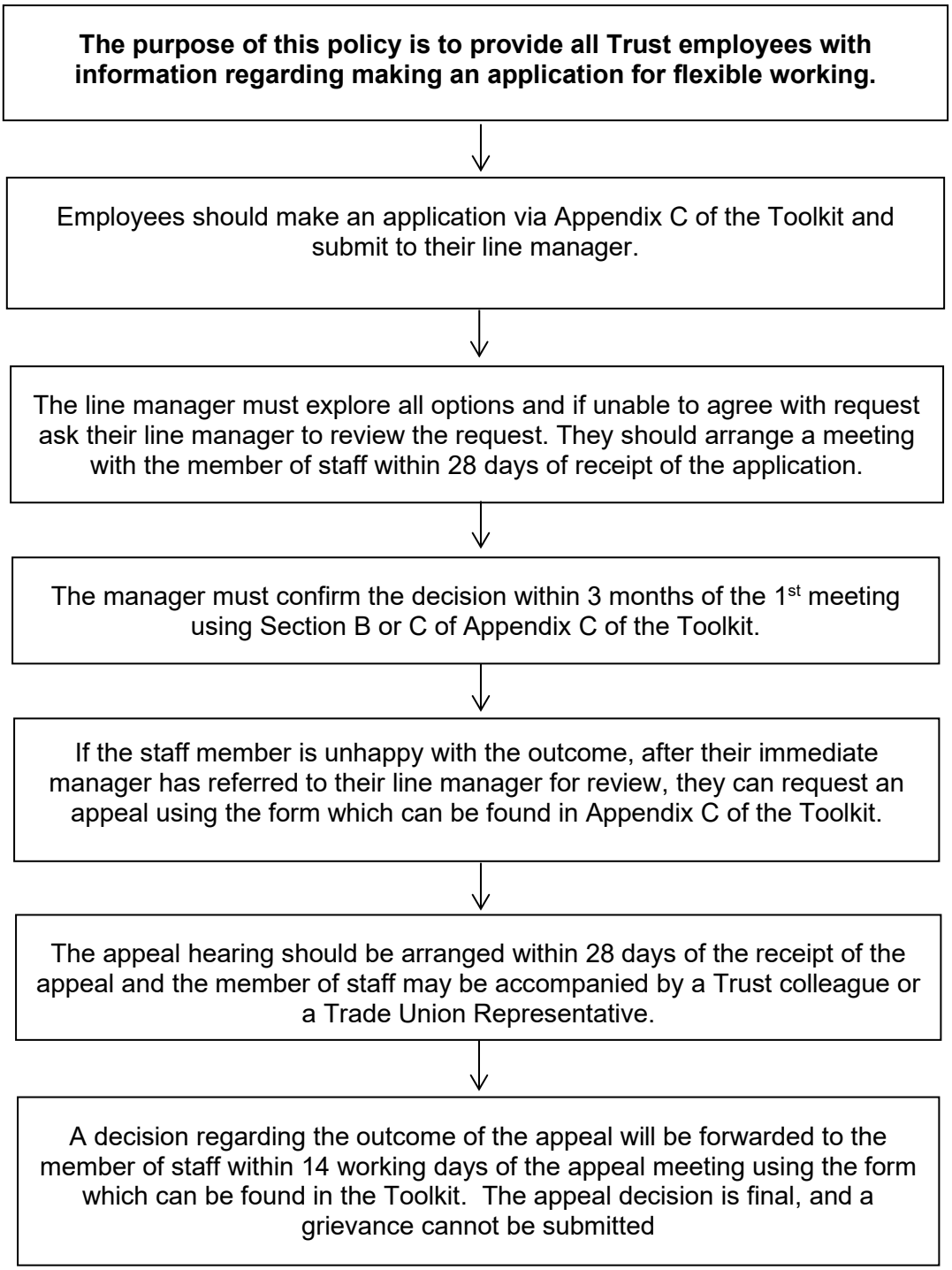
This limited defence applies where the nature of the role makes it unsuitable for individuals with particular characteristics. For example, the GOQ defence may be available where the essential nature of a job requires that it be carried out by a person of a particular sex—e.g., jobs that involve physical contact, and issues of decency or privacy arise. Similarly, under the Race Relations Act, an employer may justify employing only individuals of a particular racial background for the purposes of "authenticity" in a particular setting, such as a restaurant - e.g., Ethiopian or Indian restaurants.

However, there are very strict conditions that must be met for this defence, and the employer has the burden of proving the need to discriminate. The discriminatory characteristic must be a genuine and determining requirement of the job; it must be proportionate to apply that requirement in the particular case, and either the prospective employee must not meet the requirement or the employer must be satisfied that the person does not meet it. Employers must also ensure that before committing to positive action they have evidence to show that the targeted group is under-represented within the workforce or is likely to have a particular disadvantage in taking up or doing that type of work

Alder Hey Children's NHS Foundation Trust

E3 – FLEXIBLE WORKING POLICY

Version:	5
Name of ratifying committee:	People and Wellbeing Committee.
Date ratified:	23/11/2021
Name of originator/author:	Donna Winrow
Name of approval committee:	Employment Policy Review Group
Date approved:	October 2021
Name of Executive Sponsor:	Director of Human Resources
Key search words:	Flexible working, flexitime, part-time, job share, term time, variable, annualised, compressed, E3
Date issued:	November 2021
Review date:	November 2024


The purpose of this policy is to provide all Trust employees with information regarding making an application for flexible working.
Employees should make an application via Appendix C of the Toolkit and submit to their line manager.
The line manager must explore all options and if unable to agree with request ask their line manager to review the request. They should arrange a meeting with the member of staff within 28 days of receipt of the application.
The manager must confirm the decision within 3 months of the 1st meeting using Section B or C of Appendix C of the Toolkit.
If the staff member is unhappy with the outcome, after their immediate manager has referred to their line manager for review, they can request an appeal using the form which can be found in Appendix C of the Toolkit.
The appeal hearing should be arranged within 28 days of the receipt of the appeal and the member of staff may be accompanied by a Trust colleague or a Trade Union Representative.
A decision regarding the outcome of the appeal will be forwarded to the member of staff within 14 working days of the appeal meeting using the form which can be found in the Toolkit. The appeal decision is final, and a grievance cannot be submitted

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
5	November 2021	Donna Winrow	Current	
4.1	March 2021	Katie Toner	Archived	Extended for a further 6 months
4	June 2018	Katie Toner	Archived	
3.1	February 2018	Melissa Swindell	Archived	Interim extension
3	March 2015	Melissa Swindell	Archived	
2	July 2007	Improving Working Lives Action Group	Archived	
1	February 2004	Improving Working Lives Action Group	Archived	

Record of changes made to Flexible Working Policy – Version 5			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
2	5	Right to request Flexible working from day one of employment	To support and facilitate cultural change
3.2	5	Optional provision of information and ideally well in advance. State if request is in relation to reasonable adjustment.	To support and facilitate cultural change. Equality of opportunity
3.3	6	Expanded and updated to include regular staff engagement	To support staff and mangers
3.5	6	Reade Union Representative section expanded to support, advise and represent members	To support staff
4.1	6	Hybrid working added Carer passport added	New ways of working
6	7	Improved work / life balance added to benefits	Benefit for staff
7	7	Eligibility for all staff from commencement of employment	To support and facilitate cultural change
8.4	8	Staff able to make further applications	To reflect changing circumstances
10	9	Hybrid working section added	New way of working

Contents

1 Introduction

Alder Hey Children's NHS Foundation Trust recognises the high standards and the quality of the services it provides will be dependent upon the contribution, effort and loyalty of the staff it employs. The Trust is committed to the principles of flexible working and will aim to provide employees with the opportunity to balance their work and home lives wherever practicable.

Good flexible working arrangements will always balance the needs of the individual with three key organisational factors; patient/service user and staff experience, service delivery and capacity, and team effectiveness/work-life balance of colleagues.

2 Policy Scope

This policy will allow all Trust employees the right to request to work flexibly from day one, including temporary staff. This policy will not provide an automatic right to work flexibly, as there will always be circumstances where a desired work pattern cannot be accommodated. It aims to facilitate discussion between staff and managers to consider flexible working patterns and to find a solution that suits both the needs of individuals and the needs of the service. Employees have a responsibility to think carefully about their desired working pattern when making an application and managers are required to promote flexibility but consider the impact of the service.

Before applying for any flexible working arrangement, employees are reminded that any change in working hours may affect pay, annual leave, and NHS Pension entitlements.

3 Duties

3.1 Employee's Rights

i. To request to work flexibly
ii. To have their application considered in accordance with the set procedure and refused only when there is a clear service need for doing so
iii. Where an application is refused, to have a written explanation why
iv. To appeal against the manager's decision to refuse an application

3.2 Employee's Responsibilities

i. To provide a carefully thought out application
ii. Complete ESR
iii. To discuss their application where possible / applicable with immediate colleagues to ensure the impact on other members of the team can be assessed
iv. It is optional to provide all the necessary information to enable their manager to make an informed decision
v. To ideally ensure the application is made well in advance of when they want it to take effect, maximum timeline is 3 months

vi. To be prepared to discuss their application in an open and constructive manner
vii. Be prepared to be flexible to reach a compromise with their manager, should their desired flexible working arrangements not be met
viii. To state if the request for flexible working is being made as part of a request for a reasonable adjustment to working arrangements due to a disability.

3.3 Manager's responsibilities

i. To promote flexibility options at the point of recruitment and through regular staff engagement through one-to-ones, health and well-being conversations, appraisals and team discussions
ii. To consider requests in accordance with procedure
iii. Ensure ESR is kept updated with where the request is up to
iv. To make every effort to adhere to the time limits contained within the procedure
v. To consider where adjustments could be made regarding applications from disabled members of staff
vi. To only decline a request where there is a service need to do so and to explain this fully in writing to the member of staff
vii. To ensure that any variation in the working pattern is fully discussed with the employee including any impact on pay and / or benefits and recorded in writing
viii. To explore other possible flexible working patterns with the employee if they are unable to grant their desired flexible working request
ix. To suggest a trial period if appropriate
x. To set periodic review dates with the employee to ensure that the service can continue to accommodate the arrangements
xi. To only reject an application when the desired working pattern cannot be accommodated within the needs of the service
xii. To extend the time scales to consider the application where it is appropriate.

3.4 Human Resources Responsibilities

i. To provide managers and staff with advice relating to support with the interpretation of the Flexible Working Policy.

3.5 Accredited Trade Union Representatives Responsibilities

During the formal stages of the procedure, the employee has a right to be represented by an accredited Officer of a recognised Trade Union or Professional Association, or by a work colleague who is an employee of the Trust. The Representative will be allowed to address the hearing to put forward the employee's case and to sum up the case on the employee's behalf, however they will not be permitted to answer questions on behalf of the employee. Their role is to support, advise and represent their members.

4 Definitions

4.1 Flexible Working incorporates a wide variety of working patterns and practices. Employees can request to change the days, times, or hours they are required to work. It will be impossible to describe every example of flexible working; in

many cases these will be tailored to individual requirements. However, some of the more common ways of working that employees may wish to consider are:

i. Part-time working
ii. 'Flexi time'
iii. Compressed hours
iv. Job sharing
v. Term time working
vi. Annualised hours
vii. Additional annual leave entitlement
viii. Variable time working
ix. Career break - see the Toolkit for further details
x. Team based self-rostering
xi Home working / hybrid working - see Toolkit for full definitions of homeworkers / hybrid
xii Flexible retirement
xii Carer Passport - see the Toolkit for further details

5 Benefits to the Trust

5.1 Flexible working patterns that suit the changing circumstances of people's lives are an important way to secure a motivated and committed workforce. A commitment to Flexible Working will bring several benefits:

- Retain skilled staff and reduce recruitment costs
- Recruit trained and experienced staff back into the workforce
- Improved staff engagement
- Supports positive attendance management
- Can improve productivity

6 Benefits to the Employee

6.1 Implementation of this policy and a commitment to flexible working practices will bring several benefits to staff, as follows: -

- More ownership and control of working life
- Improved health and well-being
- Opportunities to continue with their career and keep skills up to date
- Opportunity for an improved work / life balance

7 Eligibility

7.1 This policy will apply to all Trust employees at commencement of employment.

8 Application of the Policy

8.1 Staff will have the right to request flexible working arrangements and to have such requests considered from day one of employment.

8.2 Requests for flexible working should only be rejected on specific grounds where it can be demonstrated that all options have been considered and that granting the request is likely to have a detrimental effect on the service provided to patients, or to staff.

8.3 Staff do not have an automatic right to have their working arrangements changed.

8.4 If there has been an unforeseen and significant change in their circumstances, members of staff may make further applications.

8.5 A commitment to the principles of flexible working from day one of employment will be made in the Trust's Recruitment and Selection Policy and this will be included in all job advertisements. Prospective candidates should therefore be able to discuss preferred working patterns with managers at any time during the selection process and will not be disadvantaged as a result of this.

8.6 Managers should ensure that staff are made aware of this policy and will be expected to take a proactive approach to promote flexible working.

8.7 The full procedure for the application process for Flexible Working can be found in Appendix B of the Toolkit.

8.8 The application form for Flexible Working can be found in Appendix C of the Toolkit.

9 Monitoring

9.1 Compliance with this policy will be monitored by Division Managers and the People and Wellbeing Committee against key performance indicators, as shown in the schedule below:

Monitoring	Lead Responsible	Frequency	Responsible Committee
Total number of requests by each protected characteristics and occupational groups	Division Managers	Quarterly	People and Wellbeing Committee

9.2 The findings from this monitoring will be reported by the Divisional Managers to the Human Resources Department and to the People and Wellbeing Committee as stated above.

9.3 An action plan will accompany the report to the People and Wellbeing Committee, should any deficiencies in compliance be identified. Implementation of any action plans will be monitored by the People and Wellbeing Committee.

9.4 The policy will be periodically reviewed by the HR Department and the People and Wellbeing Committee.

10 Hybrid Working

The Trust have adopted a hybrid working philosophy across the whole organisation, facilitating those who meet the criteria below to work from home for some, or all, of their working week. A 'hybrid' model of working is simply a blend of spending some of time working from home and some of time in the workplace environment (this could be clinical or non-clinical.

Eligibility

Trust employees will, as a rule, fall into one of the following four categories*:

1. Those who need to be present in the workplace (clinical or non-clinical) for all their working time in order to carry out their duties effectively
2. Those who can carry out some of their work effectively from home
3. Those whose service needs to be permanently based on a particular site, but not all the team need to be in the workplace together at the same time
4. Those who could carry out all their work effectively from home

*Employees in categories 2,3 and 4 will be eligible for consideration for home/hybrid working**.**

Applications for homeworking will be granted where the employee's line manager is satisfied that the needs of the organisation can continue to be met while the employee works from home. Homeworking must be cost-effective and ensure that there is no significant increase in workload on other colleagues. The work done by the employee must be capable of being done from home.

11 Further Information

References

GOV.UK
ACAS Guide to Flexible Working
NHS Employers
Employment Act 2008
Work & Families Act 2006
Working Time Regulations
Carers Passport
Workforce Race Equality Standard
Workforce Disability Equality Standard

Associated Documentation

(available on the Trust Document Management System (DMS))

Special Leave Policy
Maternity, Paternity, Adoption and Shared Parental Leave Policy
Retirement Policy
Recruitment policy
Mandatory Training Policy
Induction Policy
Equality, Diversity and Human Rights Policy

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form		
Policy Name	Flexible Working Policy	
Policy Overview	This policy will allow all Trust employees the right to request to work flexibly. This policy will not provide an automatic right to work flexibly, as there will always be circumstances where a desired work pattern cannot be accommodated. It aims to facilitate discussion between staff and managers to consider flexible working patterns and to find a solution that suits both the needs of individuals and the needs of the Service	
Relevant Changes (if any)	Right to request to work flexibly from commencement of employment. Addition of hybrid working	
Equality Relevance Select LOW, MEDIUM or HIGH	HIGH	
If the policy is LOW relevance, you **MUST** state the reasons here.	Click here to enter text.	
Form completed on:	Date: 26/07/2021	
Form completed by:	Name: Donna Winrow	Job Title: HR Manager

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted. (use **Equality Relevance** to assess the impact on each protected characteristic)	Protected Characteristic	Mitigation
	Age ☑ How: Click here to enter text.	For staff applying to work flexibly for reason of older age this will be covered by the flexible retirement policy. Younger staff may apply to work more flexibly
	Disability ☑ How: Click here to enter text.	Staff with disability may need reasonable adjustments that could include more flexible work arrangements
	Gender reassignment ☑ How: Click here to enter text.	Potential positive impact for employees undergoing gender reassignment process where adjusting their work patten might help them when undergoing their treatment.

	Marriage & Civil Partnership ☑ How: Click here to enter text.	All staff have the right to request flexible working
	Pregnancy or Maternity ☐ How: Click here to enter text.	For women returning from maternity leave who may apply in order to manage childcare responsibilities and work-life balance.
	Race ☐ How: Click here to enter text.	Click here to enter text.
	Religion or Belief ☑ How: Click here to enter text.	Potential positive impact on employees who may wish to work flexibly in order to observe religious practices.
	Sex ☑ How: Click here to enter text.	The policy should have a positive impact on the workforce, particularly the majority of the workforce of female gender and who the majority are more likely to have primary responsibility for childcare.
	Sexual Orientation ☐ How: Click here to enter text.	Click here to enter text.
	Human Rights (FREDA principles) ☑ How: Click here to enter text.	Equality under the FREDA principles, Article 14 Prohibition of discrimination
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	This document takes into account current employment legislation and must be implemented in conjunction with the Trust's Equalities Framework, The Trust's Equality & Human Rights Policy and Equality and Diversity legislation. Managers have a particular responsibility not to discriminate in their management practices, the provision of their service or in the employment of staff. The Trust monitors and publishes information on the profile of its workforce based on age, disability, ethnicity, gender and marital status and appropriate actions will be recommended by the Equality & Diversity Group to address any problems. Additional MI will be captured in relation to flexible working.	
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See **Gunning Principles** for public consultation requirements. **How has consultation influenced the policy?**	Trade Union Officials and Managers were consulted with during the writing and ratification of this Policy. Feedback from these groups was acted upon and the Policy was amended to reflect any comments made.	

Interdependency How will this affect other policies, projects, schemes from an equality perspective?	Special Leave Policy – E14 Maternity, Paternity, Adoption and Shared Parental Leave Policy – E22 Retirement Policy – E18 Disciplinary Policy E5 Sickness & Absence Policy E4 Bullying & Harassment Policy E24 Grievance Policy E7 Equality, Diversity & Human Rights Policy C47 Recruitment and Selection Policy – E2 Mandatory Training Policy – E21 Induction Policy – E6	
Public Sector Equality Duty Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	a) Eliminate discrimination, harassment, victimisation etc Click here to enter text.	
	b) Advance equality of opportunity Click here to enter text.	
	c) Foster good relations Click here to enter text.	
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐ It is intended that application of this policy will ensure that no group will be affected more or less favourably than another on the basis of any protected characteristic. However monitoring arrangements will be put in place to monitor the impact of this policy for reasons of age, disability, pregnancy or maternity and sex. Section 13.1 of the policy has been amended to include a breakdown of appeals that could be for reason of age, disability, pregnancy or maternity, sex as identified in the equality analysis. The policy also has an review and appeals process and advice of the Equality and Diversity Manager will be taken, if necessary, if the reason of the appeal appears to be for reason of discrimination. The HR department provides an equality monitoring workforce profile and applications for flexible working is monitored by gender, ethnicity and age. Appeals data broken down into the relevant protected characteristics will be included in the next report.	
Monitoring Include details of how the equality impact will be monitored.	The Trust monitors and publishes information on the profile of its workforce based on age, disability, ethnicity, gender and marital status and appropriate actions will be recommended by the Equality & Diversity Group to address any problems.	
Review of Equality Analysis (if indicated)	Rationale for review: Click here to enter text.	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If **MEDIUM** or **HIGH r**elevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Donna Winrow	Job title: HR Manager
Approval Committee:	Employment Policy Review Group	Date approved: 21/09/2021
Ratification Committee:	People and Wellbeing Committee	Date ratified: 23/11/2021
Person to Review Equality Analysis:	Name: Donna Winrow	Review Date: 23/11/2024
Comments:	Click here to enter text.	

Alder Hey Children's NHS Foundation Trust

MENOPAUSE POLICY – E51

Document Properties	
Version:	1
Name of ratifying committee:	People and Wellbeing Committee
Date ratified:	20 March 2024
Name of originator/author:	Melissa Evans, Jeanette Chamberlain
Name of approval committee:	Employment Policy Review Group
Date approved:	28 February 2024
Name of Executive Sponsor:	Chief People Officer
Key search words:	Menopause, health, SALS, sickness absence, special leave
Date issued:	April 2024
Review date:	April 2027

Version Control, Review and Amendment Log

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	February 2024	Jeanette Chamberlain and Melissa Evans	Current	Introduction of new policy

Record of changes made to the Menopause Policy			
Section Number	**Page Number**	**Change/s made**	**Reason for change**

CONTENTS

1.0 Introduction

1.1 Alder Hey Children's NHS Foundation Trust (the Trust) recognises that the high standards and quality of the services it provides for our children and young people are achieved through the dedication and efforts of our people.

Within Alder Hey NHS Foundation Trust, **45%** of employees are women between the age of 40-50+. This means that a significant number of colleagues will be going through perimenopause or menopause. In addition to this there will be a proportion of colleagues who experience early menopause or menopause brought on by surgical interventions.

1.2 The Trust also recognises that menopause can bring issues for individuals which can impact upon their work and overall health and wellbeing. Figures collated in Alder Hey at the date of writing this policy demonstrate that of circa 4000 members of staff, approximately 45% of those staff are at the age of peri/menopause age.

1.3 It is to the benefit of all staff that we, as a responsible employer, work with staff to support them during menopause, to help find mutually beneficial arrangements, maximising staff retention and wellbeing and help staff remain well whilst in work. In recognition of this, and in line with our organisational values, this policy outlines the range, and potential impact, of varying menopause symptoms that are experienced as well as to promote understanding of what our colleagues are experiencing, and some information and signposting which could support staff affected by the menopause with a compassionate approach.

1.4 Anyone can be affected by hormonal changes during their lives, including during the stages of the menopause. These can bring about symptoms which could affect colleague. Alder Hey recognises that the menopausal symptoms identified within this policy can also be experienced by transgender, non-binary and intersex employees. Transgender employees may be affected due to the natural menopause or as a result of the treatment and/or surgery they are undergoing. Transgender, non-binary and intersex employees may choose not to associate their symptoms to the menopause as this will disclose their trans status. Managers are therefore reminded of the importance of responding promptly to requests for support from all employees.

1.5 The menopause policy has been created in partnership with trade unions as a commitment to work to improve response to menopause as well as taking into consideration the work already undertaken by NHS England (NHSE). Colleagues can find information and resources available via NHSE Menopause Guidance (NHS England » Supporting our NHS people through menopause: guidance for line managers and colleagues) which can be used in conjunction with this policy.

2.0 Policy Scope

2.1 This policy details both the support and resources that are available to **all Trust employees** in respect of the perimenopause/ menopause and whether they are directly or indirectly impacted, therefore all Trust employees are covered by this policy. The right also covers employees on fixed term or other temporary contracts.

2.2 The policy underlines the need for recognition of the psychological and physical impacts of the phases of the menopause being reflected in organisational policy and practice, addressing any potential for occupational health provision line manager support and also identifies where advice and support can be found. This policy also outlines the actions for managers that are expected in order to maximise employee health and wellbeing.

3.0 Rights and Responsibilities

3.1 Employee's Responsibilities

i. Should take personal responsibility to look after their health and wellbeing.
ii. Try to be open and honest in their conversations with line or department managers, HR, SALS, and/or the Occupational Health Service, as appropriate.
iii. Where employees feel they are unable to speak to their line manager in relation to menopause, they can speak to SALS, a member of HR, their Trade Union, Occupational Health Service.
iv. If an employee perceives their line manager is not supporting them with adjustments (which are individual to each employee, see section 5.2 for further information), they can seek guidance from alternative sources in their department or as listed above.
v. Contribute to the maintenance of a safe and healthy working environment for themselves and others, alerting their line manager where potential problems arise.
vi. Be willing to help and support their colleagues.
vii. Should be understanding of any necessary, supportive measures that their colleagues are receiving as a result of their menopausal symptoms.

3.2 Manager's Responsibilities

i. Managers are crucial in supporting colleagues experiencing the menopause. Some colleagues may not need any assistance or require any additional support. Some colleagues may have much more severe symptoms and could require additional support at work to help them cope with the impact of their symptoms in the workplace. Each situation is different and there is no standard approach to supporting colleagues

experiencing the menopause apart from having an open, compassionate approach.

ii. Recognising the sensitivity that some colleagues may feel in discussing menopause, other options should be explored in terms of offering colleagues a place to talk and to look for support.

iii. Should familiarise themselves with the content of this policy and what support is available within the Trust as well as signposting colleagues to external sources of support, which can be found on our intranet staff support page and at the back of this policy document.

iv. Be ready and willing to have open discussions about menopause, appreciating the personal nature of the conversation, and treating the discussion sensitively and professionally. This can be done as part of a Menopause Health and Wellbeing Conversation (Appendix B).

v. Record all supportive measures that have been agreed and ensure that the actions are implemented and supported within the workplace.

vi. Ensure ongoing, open dialogue with their colleagues and that supportive measures and risk assessments are regularly reviewed to ensure they remain appropriate for employees.

vii. Be aware that the Staff Advice and Liaison Service and HR can offer support and guidance for colleagues and managers who need to understand more about menopause.

3.3 Human Resources Responsibilities

i. To provide managers and employees with advice relating the Menopause Policy

ii. To provide advice and guidance to employees on other specific policies that may support them with supportive measures when going through the menopause.

iii. To provide advice and guidance to line managers in supporting their staff members who have raised concerns to them about the menopause symptoms they are experiencing and signposting to appropriate support.

3.4 Chief People Officer Responsibilities

The Chief People Officer must ensure the HR team are fully aware and trained in the relevant people management policies and procedures to enable team members to provide clear and consistent advice on matters arising that employees and managers may seek advice on.

3.5 Staff Advice and Liaison Service (SALS)

The Staff Advice and Liaison Service provides support to all employees who approach the team. The service is a one door listening service available to anybody who works within the community of Alder Hey. There are no referral or criteria to be able to access the service. Signposting or self-referral can be made to SALS for anybody who thinks they are experiencing symptoms of the menopause that is impacting on their day-to-day life or when they are in the workplace. SALS can support with signposting, resources and being there for

our staff, as well as invitation to the Menopause Support Group which currently takes place monthly and is a well utilised support group for all colleagues.

3.6 Occupational Health Service

The service can be utilised to provide appropriate clinical advice to support and enable supportive measures to be made, as required, to enable colleagues to fulfil their role, in a safe a supportive manner. A discussion with a line manager or department manager will need to take place so that they can complete a referral into the service on an employee's behalf.

4 The definitions of all phases of menopause

4.1 The menopause transition is a natural phase of life when women stop having periods as a result of hormonal changes with a decrease in oestrogen levels. It usually occurs between the ages of 45 and 55 and typically lasts between four and eight years, although it can last longer (and can begin earlier than 45).

4.2 Premature menopause can happen naturally for 1 in 100 individuals (or because of illness or surgery). This may also be more common in trans, non-binary or intersex staff where hormonal treatments or surgeries may affect the age at which menopause starts.

4.3 Menopause is a biological stage that refers to the time in life when periods stop, and the natural reproductive cycle ends. Usually, it is defined as having occurred when there has not been a period for 12 consecutive months (for those reaching menopause naturally). The changes associated with menopause occur when the ovaries stop maturing eggs and secreting oestrogen and progesterone.

4.4 Perimenopause is the time leading up to menopause when ovulation cycles and periods can be irregular, continuing until 12 months after the final period. Perimenopause can often last for four to five years (though it may continue for many more years for some people, whilst lasting just a few months for others). During the perimenopause the levels of hormones produced by the ovaries fluctuate leading to menstrual irregularities in the time between periods

4.5 Post menopause is the time after menopause has occurred, starting when there has not been a period for 12 consecutive months. There is potentially an increased risk of certain conditions, including heart disease and osteoporosis (brittle bones) during post-menopause because of lower levels of certain hormones. These risks are higher for those who have had an early or premature menopause.

4.6 There are other circumstances in which symptoms maybe experienced. Whilst menopause is usually a process involving gradual change, it can sometimes be sudden and acute following serious illness, medication, or surgery.

4.7 Those who suffer from sudden menopause tend to experience more severe symptoms and may require treatment and/or post operative care to manage further problems.

4.8 Younger women undergoing treatments for conditions such as endometriosis and infertility may experience menopausal symptoms whilst receiving treatment. Surgical and medical treatments as part of an individual's gender transition can result in menopausal symptoms. Treatments for some forms of cancers may also bring on sudden menopause.

4.9 Many women are working more years in peri, menopause, and post menopause than in their fertile years. The need to manage both work and family and/or caring responsibilities as mentioned above can present significant challenges at this time of life, when we may feel we need to work longer to generate sufficient pension support.

4.10 Many staff still feel uncomfortable discussing menopause at work. Recent studies indicate that women may hide and/or self-manage their symptoms, developing a degree of paranoia and anxiety about how their performance might be affected, or work harder to compensate (ACAS Menopause at work)

5.0 Menopause and the law

5.1 There is relevant legislation which addresses the impact that menopause symptoms can have in the workplace, which colleagues should be aware of:

i. **The Health and Safety at Work Act (1974**) The Act requires employers to ensure the health, safety and welfare of all employees - and this will include women experiencing the menopause. Employers are required to carry out risk assessments and these should include specific risks to menopausal women, considering their specific needs and ensuring that the working environment will not worsen their symptoms.

ii. **The Equality Act (2010)** The Act protects people from discrimination in the workplace because of 'protected characteristics' and includes both direct and indirect discrimination and harassment. This places a legal obligation on the Trust to consider how it can positively contribute to a fairer society through eliminating unlawful discrimination, advancing equality of opportunity, and fostering good relations between people who share a 'protected characteristic' and those who do not. This includes removing or minimising disadvantages suffered by people due to their protected characteristics, taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

5.2 Some colleagues may experience menopause symptoms, that have a substantial and long term adverse effect on their ability to carry normal day-to-day activities. In these instances, their employer is legally required to make reasonable adjustments to support them in their workplace. Please refer to the Trust's Reasonable Adjustments Policy for further detail and information.

6.0 How menopause can affect colleagues with protected characteristics.

6.1 There are many personal circumstances and factors that may affect how someone experiences the menopause, including the protected characteristics set out in the Equality Act (2010).

6.2 Some employees may have more than one protected characteristic and therefore may experience multiple levels of barriers and discrimination. Employees needs should be addressed sensitively on an individual basis in a considerate and compassionate manner.

6.3 The Trust recognises that the menopausal symptoms can also be experienced by transgender, non-binary and intersex employees. Transgender employees may be affected due to the natural menopause or as a result of the treatment and/or surgery they are undergoing.

6.4 Some employees may choose not to associate their symptoms to the menopause as this will disclose their transgender status. Line managers are therefore reminded of the importance of responding promptly and sensitively to requests for support from all employees.

7.0 How line managers can support colleagues experiencing perimenopause/ menopause

7.1 The most important and valuable thing a line manager can do is listen and wherever possible, respond sympathetically and compassionately to any requests for adjustments at work from their staff members. To support informal conversations between the line manager and their employee, there is a Menopause Health and Wellbeing Conversation within the policy (Appendix B). This document will also help both the line manager and employee when agreeing supportive measures/modifications to support the employee manage their menopause symptoms within the workplace. This document can then be reviewed at further informal discussions about the employee's health and wellbeing.

7.2 Colleagues who are experiencing the menopause (whether directly or indirectly) may need sympathetic, flexible and compassionate support from their line manager. As with any longstanding health-related conditions, this support can make a significant difference to how they deal with the menopause whilst in work, therefore enabling them to continue working well and productively.

7.3 Managers can only be sympathetic and supportive though if they are aware that an employee is experiencing difficulties and we therefore encourage staff wherever possible to have a conversation about what is happening for them.

7.4 Some colleagues may feel uncomfortable or embarrassed approaching their manager to discuss any difficulties in managing their menopausal symptoms. This could particularly be the case if their manager is younger than them or

male and, as menopause can affect levels of confidence, it may be helpful if the person they are talking to has experience of the menopause. This may include individuals who may be embarrassed to admit that they are affected by the experiences of their partner.

7.5 It is therefore important that as a manager, you are aware of the symptoms associated with the menopause and understand the issues affecting people going through it. This will help in fostering an environment where we are all more comfortable talking about the menopause, the symptoms and measures that could help in minimising these. As already referenced in this document more information can be found here NHS England » Supporting our NHS people through menopause: guidance for line managers and colleagues

7.6 You will need to be sensitive to any feelings of discomfort, listen to concerns and consider what can be done to reduce or minimise the impact symptoms may be having on the staff member's performance within the workplace – for example if supportive measures could be implemented to allow them to manage their symptoms better.

7.7 Line managers should be aware that each individual can be affected by perimenopause/ menopause in numerous ways, causing multiple symptoms, some of which will affect performance at work more specifically and as a result will potentially require consideration more than others. The most common symptoms can include:

- Hot flushes/night sweats
- Fatigue
- Concentration problems
- Anxiety/Increased anxiety
- Insomnia
- Recall/memory problems
- Palpitations
- Migraines and headaches
- Joint stiffness, aches, and pains
- Reduced muscle mass.
- Skin irritation
- Urinary Problems
- Brain fog and associated impact on memory

This list is not exhaustive. There is a detailed list of symptoms contained within Appendix D.

7.8 Colleagues with neurodiversity may experience exacerbated symptoms of their neurodiversity whilst going through menopause.

7.9 There may be cultural/religious beliefs that need to be taken into account when supporting colleagues experiencing menopause.

7.10 Things to remember/consider when supporting staff with menopause:

i. You will need to maintain confidentiality in handling health information about the menopause.

ii. Any specific needs identified, including supportive measures that are agreed, should be documented locally and the record kept between the employee and their line manager to enable ongoing review to ensure they remain suitable.

iii. You should be aware of the potential impact of menopause on performance. If someone's performance suddenly dips, it is worth considering whether the menopause may be playing a part in this and what you can do to support this.

iv. Colleagues should not experience any detriment because they may need time off during this time. Any sickness absences should be managed in line with the Trusts Supporting Sickness and Attendance Policy. However, the Manager in knowing "their employee" could explore with their employee if they are sick or whether temporary modifications in their job role could be implemented to support them remaining in work. For example, if an employee is experiencing flooding or hot flushes, is it possible to support them working from home? It must be acknowledged that it may not be possible for every service to implement temporary modifications or support.

7.11 Recommendations and specific guidance to support colleagues with menopause.

- Ensure that all information shared by the employee is treated in the strictest confidence and is not shared further without the employee's consent.

- Listen to and gain an understanding of any concerns the employee has about their issues or symptoms, avoiding assumptions.

- Discuss timescales and leave requirements if this has been raised as part of the discussion. It is worth underlining that perimenopause and menopause symptoms do not have an indicative timeline for resolution and symptoms can fluctuate, change, or become exacerbated.

- Take account of individual and service/operational needs but be supportive when dealing with requests to work flexibility or for leave, being mindful of the importance of being supportive of attendance at appointments and the unpredictability of symptoms.

- If more support is needed, managers may find it helpful to complete a Wellness Action Plan (WAP) to identify the adjustments made to the working arrangements of that staff member (Appendix C). Managers must also consider undertaking an appropriate risk assessment with their employee.

- Be prepared to discuss the points that the employee raises and promote supportive conversations about the menopause and its effects and be aware of the personal nature of these conversations.

- Be open to a request to have someone to support the member of staff in the conversation because of the personal nature of the discussion.

- Recognise that every experience of the menopause will be individual, and for some staff it can feel extremely distressing, physically, and psychologically, as they navigate the changes that they are experiencing. It is important to have an open mind and not use your own personal experience, or that of any friends, relatives, or other staff members to measure whether you believe that the staff member's symptoms are reasonable.

- Provide dedicated time and quiet space for 1:1s; promote avenues of support, signposting and links to organisational resources such as supportive measures, flexible working, special leave, and any changes to the working environment such as quiet spaces that you can facilitate.

- Where additional support is required, provide information on specific health and wellbeing services. These can be found here: Staff Advice and Liaison Service - My Alder Hey, Human Resources - My Alder Hey. In addition there are resources detailed in Appendix A of this policy which managers and employees may find helpful.

- Promote a culture and environment that values diversity, shows dignity, respect, fairness, and equality.

- Do not tolerate or express what you consider to be “workplace banter” which may be interpreted negatively.

- Be aware there is a subjective range of symptoms that can be experienced all of which could make the employee feel they’re presenting themselves in a less favourable way to their colleagues or line manager.

- Consider all flexible working requests in accordance with the Flexible Working Policy

- A Menopause Health and wellbeing conversation could be useful, in order to consider the specific needs of individuals going through the menopause and ensure that the working environment will not make their symptoms worse. Particular issues to consider are temperature, ventilation and the materials used in any uniform which is provided. Welfare issues including toilet facilities, access to shower facilities/bathrooms, and access to cold drinking water should also be considered.

- Consider any changes impacting performance, attendance, or behaviour and whether the impact of menopause and its distressing symptoms may be an

issue – do not launch capability or conduct processes before these elements have been reasonably considered.

8.0 Support for employees

8.1 Guidance indicates that keeping healthy is particularly important to support menopause. Current health promotion advice highlights the importance of lifestyle choices before, during and after the menopause. Lack of sleep, stress, unhealthy eating and unhealthy lifestyle can increase the symptoms of menopause. In addition to helping with certain symptoms, the following may also help reduce the risks of osteoporosis (brittle bones), diabetes and heart disease in later life:

- Eating healthily and regularly – research has shown that a balanced diet can help in alleviating some symptoms, in keeping bones healthy and in not gaining weight.

- Drinking plenty of water.

- Exercising regularly - to reduce hot flushes, improve sleep, boost mood and maintain aerobic fitness levels. Accessing the Alder Hey Physical Health and Wellbeing Group via staffadvice@alderhey.nhs.uk maybe helpful to explore what physical activity is available within the Trust and the local community.

- Not smoking – to help reduce hot flushes and the risk of developing serious conditions such as cancer, heart disease and stroke.

- Ensuring alcohol intake is within recommended levels and cutting down on caffeine and spicy food – all of which can trigger hot flushes.

- Having access to natural light.

- Staying cool at night – wearing loose clothes in a cool and well-ventilated room to help with hot flushes and night sweats.

- Ensuring adequate rest and relaxation – to reduce stress levels and improve mood (through, for example, activities such as mindfulness, yoga or tai chi).

- Menopause symptoms are highly individual; they can be sensitive and cause embarrassment for some, for varied lengths of time, so it is entirely understandable for some staff to feel unable to share and explore sensitive and personal symptoms with their managers. There are options to help you thinking about accessing support within this policy.

- Seek support, advice, or info from the Trust's peer support Menopause Virtual Group or via Staff Advice and Liaison Service who can offer 1:1 supportive signposting.

- Approach someone in the workplace with whom you do feel comfortable discussing your issues who could support you in the conversation – e.g., your manager, a colleague, another manager, trade union representative, HR representative or SALS Pal in their work area.

- Sharing your experience and/or symptoms with colleagues to promote understanding if you feel comfortable.

- Recording and monitoring your symptoms and/or their severity may be helpful to understand how your wellbeing may be affected and how you can seek support via your GP. There are some useful tools that can be used to help with recording/monitoring symptoms and more details can be found in the appendices of this policy.

- Considering a change in working hours or pattern or remote working if/when you are office based (flexible working application)

- Whether you could work from home more frequently or at short notice when your symptoms are exacerbated (taking into account the business needs of your service)

- Consider a reduction in travel or increased comfort breaks, dialling into some meetings or holding virtual meetings instead of face-to-face.

- If necessary, request an occupational health review from your line manager.

- Approach your line manager or a trusted colleague to have a Menopause Health and Wellbeing Conversation which may help open up dialogue.

9.0 Monitoring

Any workforce data reporting will be anonymised and reviewed on a regular basis as appropriate by the Divisional/Corporate Services teams, People and Well Being Committee and Trust Board

The People and Well-Being Committee will ensure that this policy is reviewed at the necessary intervals and updated as appropriate.

10.0 Associated Documentation

(available on the Trust Document Management System (DMS))

Reasonable Adjustments Policy
Flexible Working Policy
Supporting Sickness and Attendance Policy
Special Leave Policy

11.0 Equality Impact Assessment

The Trust is required to ensure all of its policies are assessed to ensure they do not disproportionately impact on people who have protected characteristics as set out in the Equality Act 2010. Where it is identified that the policy may be at risk of impacting negatively on any group the Trust is required to show how it intends to mitigate against this. The following Equality Impact Assessment has been undertaken relating to the Menopause Policy.

Equality Impact Analysis (EIA)		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form		
Policy Name	Menopause Policy	
Policy Overview	The policy underlines the need for recognition of the psychological and physical impacts of the phases of the menopause being reflected in organisational policy and practice, addressing any potential for occupational health provision line manager support and also identifies where advice and support can be found. This policy also outlines the actions for managers that are expected in order to maximise employee health and wellbeing.	
Relevant Changes (if any)	Click here to enter text.	
Equality Relevance Select LOW, MEDIUM or HIGH	MEDIUM	
If the policy is LOW relevance, you **MUST** state the reasons here.	Click here to enter text.	
Form completed on:	Date: 23/01/2024	
Form completed by:	Name: Melissa Evans	Job Title: HR Manager

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and	Protected Characteristic	Mitigation
	Age ☑ How: Menopause symptoms typically impact individuals in	The policy provides support and guidance for colleagues who are either experiencing or line managing an individual with menopausal

include details of how they may be impacted. (use **Equality Relevance** to assess the impact on each protected characteristic)	their forties and older. However, the policy emphasis that employees of any age may experience symptoms/the onset or menopause	symptoms. The policy identifies a typical age that the onset of symptoms can begin. However, it is also clear that this is guide and younger/older employees can access and use the support included in this policy of they are experiencing symptoms.
	Disability ☑ How: Individuals with long term health conditions/disabilities may be more adversely impacted by menopause symptoms	The policy identifies that colleagues with disability can be disproportionately more impacted by menopause symptoms, and that some menopause symptoms that are experienced may actually be considered to be a disability. The policy provide support to individuals as well as highlighting both the legal responsibility of managers/the Trust to make reasonable adjustments and signposting to other relevant Trust policies.
	Gender reassignment ☑ How: Transgender men, non-binary or intersex colleagues will experience menopause symptoms	The policy identifies that menopause symptoms will impact Transgender men, non-binary or intersex colleagues. It emphasises that managers should treat all colleagues sensitively and confidentially if they choose to share their menopause experience/symptoms and should make no assumptions or judgement on what support is needed.
	Marriage & Civil Partnership ☐ How: Click here to enter text.	Click here to enter text.
	Pregnancy or Maternity ☐ How: Click here to enter text.	Click here to enter text.
	Race ☐ How: Click here to enter text.	Click here to enter text.
	Religion or Belief ☐ How: Click here to enter text.	Click here to enter text.
	Sex ☑ How: Menopause symptoms will predominately impact female colleagues	The policy provides advice, guidance and support for colleagues, as well as their line managers, with their menopause symptoms in the workplace. Colleagues with partners experiencing symptoms may also indirectly find reading the policy helpful for them to support their partner

	Sexual Orientation ☐ How: Click here to enter text.	Click here to enter text.
	Human Rights (FREDA principles) ☐ How: Click here to enter text.	Click here to enter text.
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	This document takes into account current employment legislation and must be implemented in conjunction with the Trust's Equalities Framework, The Trust's Equality & Human Rights Policy and Equality and Diversity legislation. Managers have a responsibility not to discriminate in their management practices, the provision of their service or relation to the employment of staff and practices while in employment with the Trust. The Trust monitors and publishes information on the profile of its workforce based on age, disability, ethnicity, gender and marital status and appropriate actions will be recommended by the People and Well-Being Committee to address any issues arising that suggest the Trust is not meeting its obligations in relation to fair and non-discriminatory treatment of all employees in relation to menopause	
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See **Gunning Principles** for public consultation requirements. **How has consultation influenced the policy?**	Trade Union Officials and managers were consulted with on the development and ratification of this Policy. Feedback from these groups was acted upon and the Policy was amended to reflect any comments made.	
Interdependency How will this affect other policies, projects, schemes from an equality perspective?		
Public Sector Equality Duty Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	a) Eliminate discrimination, harassment, victimisation etc The requirements have been considered and met in that the purpose of this policy is to ensure compliance with the Public Sector Equality Duty which includes eliminating discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010.	
	b) Advance equality of opportunity The requirements have been considered and met in that the purpose of this policy is to ensure compliance with the Public Sector Equality Duty which includes to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.	
	c) Foster good relations The requirements have been considered and met in that the purpose of this policy is to ensure compliance with the Public Sector Equality Duty which includes to foster good relations for all colleagues experiencing menopause symptoms, including	

	both colleagues who share a relevant protected characteristic and those who do not share it.	
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐ It is intended that application of this policy will ensure that no group will be affected more or less favourably than another on the basis of any protected characteristic. However, monitoring arrangements will be put in place to monitor the impact of this policy for reasons of age, disability, pregnancy or maternity and sex.	
Monitoring Include details of how the equality impact will be monitored.	The Trust monitors and publishes information on the profile of its workforce based on age, disability, ethnicity, gender and marital status and appropriate actions will be recommended by the People and Well-Being Committee to address any problems.	
Review of Equality Analysis (if indicated)	Rationale for review: Click here to enter text.	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If **MEDIUM** or **HIGH r**elevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Melissa Evans Jeanette Chamberlain	Job title: HR Manager SALS Manager
Approval Committee:	Employment Policy Review Group	Date approved: 28/02/2024
Ratification Committee:	People and Well-Being Committee	Date ratified:
Person to Review Equality Analysis:	Name:	Review Date:
Comments:	Click here to enter text.	

APPENDIX A - Resources, Useful Websites, Links and Tips

All employees should be provided the opportunity to have an annual Personal Development Review (PDR) with their line manager. As part of their PDR, employees are encouraged to have a wellbeing conversation, which may be the opportunity to share any support that is needed whilst an employee is experiencing symptoms of the menopause.

You can find guidance documents and more information regarding the wellbeing conversation on intranet at the link below; this includes a 15-minute video from our SALS team who talk more about it and share some top tips for making it as effective as possible.

Working and Learning at Alder Hey - Performance and Development Review

Resources and Information in Relation to Menopause:

Staff Advice and Liaison Service - My Alder Hey

Menopause & Me| Menopause Symptom Interactive Checklist (menopauseandme.co.uk)

https://www.nhs.uk/conditions/menopause/

https://www.menopausematters.co.uk/

https://simplyhormones.com/

https://www.unison.org.uk/content/uploads/2019/10/25831.pdf

https://www.rcn.org.uk/professional-development/publications/rcn-menopause-and-work-uk-pub-009327

https://www.nice.org.uk/guidance/ng23

https://thebms.org.uk/

https://henpicked.net/

https://www.balance-menopause.com/balance-app/

The Menopause Charity - Menopause Facts, Advice and Support

https://www.bbc.co.uk/news/topics/cxwkx729dx2t/menopause

CIPD Guidance on Menopause (www.cipd.co.uk/knowledge/culture/well-being/menopause)

ACAS Menopause at Work (www.acas.org.uk/menopause)

NHS Employers (www.nhsemployersorg/articles/menopause-and-workplace)

Alder Hey Flexible Working Policy Document Management System - Alder Hey Document Library - Policies (sharepoint.com)

Alder Hey Supporting Sickness and Attendance Policy Document Management System - Alder Hey Document Library - Policies (sharepoint.com)

Alder Hey Special Leave Policy Document Management System - Alder Hey Document Library - Policies (sharepoint.com)

Optima Health (Occupational Health) Occupational Health Optima Health - My Alder Hey

RMM_HRT-in-a-nutshell.pdf (rockmymenopause.com) – HRT information and Guidance

V2_RMM_Menopause-during-covid-for-patients-2.pdf (rockmymenopause.com)- Guide for thinking about meeting with your GP for a menopause appointment.

What Is Menopause? Age, Signs, Symptoms, and Stages (flo.health) - Website that includes lots of information about Menopause.

Equality and Human Rights Commission – Menopause in the workplace: Guidance for employers | EHRC (equalityhumanrights.com)

Appendix B - Menopause Health and Wellbeing Conversation

This template has been developed to support line managers when having informal conversations about their employees about their health and wellbeing, specifically in relation to perimenopause/menopause symptoms that the individual may be experiencing.

It is not a requirement of the policy to use this document as you and your employee may have an alternative way to record informal wellbeing discussions as well as agreed actions, support and adjustments for the employee, but merely a supportive way to open up Menopause Conversations.

About you:

Your name:	
Your Line Manager	
Date of menopause wellbeing conversation	

1. **How are you / How are you feeling today? Is there anything that would be helpful to share today about your current experience/symptoms of Peri/Menopause.**
2. **Do you know how to access Health & Wellbeing support at work, specifically around menopause when you need it? What can we (your manager / team / organisation) do to improve access?**

3. **What can we do to proactively support you to stay physically and mentally well in work particularly in relation to the menopause?**
4. **How can we support you to manage your perimenopause/menopause symptoms in work?**

Your Action Plan
Use the table below to record any actions that you have agreed in the meeting. You may also want to set a date for a follow up wellbeing conversation and to review the agreed actions.

What will you do to support your health and wellbeing particularly in relation to Peri/Menopause?	.
What will your manager do to support your health and wellbeing at this time?	

When will you review your wellbeing plan together?	

Appendix C Wellness Action Plan

The latest version of the Wellness Action Plan (WAP) template can be found online at the below website address:

mind-guide-for-employees-wellness-action-plans_final.pdf

Appendix D – List of possible symptoms of perimenopause

Section 7.7 of this policy includes the most typical menopause symptoms that colleagues may experience. However, there are many menopause symptoms that may be experienced and more are detailed below:

- Palpitations
- Chest pain
- Breast tenderness
- Itchy skin
- Dry Skin
- Rosacea
- Increase in thrush
- Memory Loss
- Foot pain
- Muscle Loss
- Increase in BV
- Scalp hair loss
- Unwanted hair growth
- Sexual dysfunction
- Body odour change
- Burning mouth
- New allergy
- Urinary urgency
- High libido
- Urinary Infections
- Nocturia (getting up at night)
- Thin skin
- Collagen loss
- Crying
- Brain Fog
- Fatigue
- Anxiety
- Headache
- Joint stiffness
- Vulval itch
- Acne
- Poor libido
- Joint Pain
- Insomnia
- Tinnitus
- Gum disease
- Watery eyes
- Night Sweats
- Cold flushes
- Hot flushes
- Dry eyes
- Poor concentration
- Anger/ Rage /Irritability
- Low mood
- Vaginal Dryness
- Worsening PMS
- Migraines
- Word finding difficulty
- Vaginal discharge
- Perineal itch
- Periods decreased frequency
- Weight gain
- Chest tightness
- Constipation
- Gastric reflux
- Frozen shoulder
- Histamine sensitivity
- Period increased frequency
- Urinary incontinence
- Heavier periods
- Vulval/ vaginal electric shocks

Alder Hey Children's NHS Foundation Trust

E13 – ORGANISATIONAL CHANGE POLICY

Version:	4
Name of ratifying committee:	People and Wellbeing Committee
Date ratified:	18/05/2021
Name of originator/author:	Melissa Caitens (HR Advisor) Alan Rigby (HR Manager)
Name of approval committee:	Employment Policy Review Group
Date approved:	11/05/2021
Name of Executive Sponsor:	Director of HR and OD
Key search words:	Organisational Change, Workforce Planning, Restructures, Redeployment, Pay Protection, Redundancy, TUPE Transfers, Downgrading, At Risk, Ring-fenced,
Date issued:	May 2021
Review date:	May 2024

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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
4	May 2021	Melissa Caitens and Alan Rigby	Current	
3.1	April 2021	Sarah Marshall	Archived	Extension
3	June 2018	Sarah Marshall	Archived	
2.1	February 2018	Maria Salcedo, HR Manager; Marianne O'Hanlon, Head of Workforce Transformation; Mike Travis, Staffside Chair/ RCN rep; Andy Hodgkinson, UNITE rep.	Archived	Interim update
2	March 2013	Maria Salcedo, HR Manager; Marianne O'Hanlon, Head of Workforce Transformation; Mike Travis, Staffside Chair/ RCN rep; Andy Hodgkinson, UNITE rep.	Archived	
1	November 2005	HR Department	Archived	

Record of changes made to Organisational Change Policy – Version 4			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Revised and updated to include current best practice and guidance. Also amended references to legislation	Necessary for the effective use of the Policy
	5	Removed "Quick Ref Guide".	Not necessary within Policy
14	25	Added further information re: Staff Support	To include additional options for staff support
All	All	Amendments to formatting and flow of the policy	To improve use of the Policy

Contents

1 Introduction

1.1 Alder Hey Children's NHS Foundation Trust (The Trust) is committed to creating as secure an employment environment as possible and to the fair and consistent treatment of all staff by means of effective and efficient management and workforce planning. Alder Hey is committed to its vision to provide world class healthcare for children and young people. In order to meet this vision we must be able to respond to our patients and the commissioner's needs which will require the organisation and its employees to undergo transformation and organisational change. As a provider of excellent care we must embrace changes to our services as this will benefit the patients that we care for.

1.2 In doing so, the Trust needs to be able to provide flexible, patient led services which are suited to the patient's needs. In some circumstances, this may require changes to working practices which may impact on employee's contractual arrangements, changes to team structures/role design, an increase or reduction in the number of posts required to deliver services or result in a transfer of services either in or out of the organisation.

1.3 This policy demonstrates the commitment of Alder Hey to support staff affected by change and deal with change in a fair, consistent and sympathetic manner to minimise the effect on employees concerned. Alder Hey recognises that from time to time change can be a difficult and stressful situation to deal with. However, the Trust will endeavour to effectively communicate, support, consult and involve its staff in organisational change, because the success of the change depends greatly upon the attitudes and skills of those affected by it. This will therefore allow change to occur in an open, transparent and structured way across the organisation.

1.5 Alder Hey is committed to ensuring that employees affected will not be discriminated against for any reason identified in The Equality Act 2010, on the grounds of; age, being or becoming a transgender person, marriage or civil partnership, pregnancy or maternity leave, disability, race (including colour, nationality, ethnic or national origin), religion, belief or lack of religion/belief, sex, sexual orientation.

1.6 It is the responsibility of every Manager proposing a change to working practices, conditions, structures etc. to work in partnership and consult with employees, accredited and recognised Trade Unions or Professional Associations at the earliest opportunity in accordance with this Policy. In addition, the Joint Consultation and Negotiating Committee (JCNC) will be advised in advance of any major Trust Wide Organisational Change.

1.7 Staff have the right to be accompanied at any group or individual meetings throughout the consultation and implementation stages by a representative of their recognised Trade Union or Professional Association employed by the Trust, work colleague or a Full time Officer of a recognised Trade Union.

1.8 Where proposed change involves a reduction in staffing levels, all measures will be considered to reduce the need for compulsory redundancies e.g.

Restriction on recruitment across the Trust, reduction in overtime, review of temporary or agency staff contracts, freezing vacancies, retraining or redeployment, voluntary early retirement and voluntary redundancy.

1.9 The advice of Human Resources must be sought by the Manager leading that change, during the planning stage.1.10 Where organisational change is proposed, communication with staff, recognised Trade Unions and staff organisations should be initiated as early as is practicably possible.

1.11 Consideration will be given to the impact on employees who have personal commitments outside work i.e. carer responsibilities, childcare arrangements as well as the impact on employees who have a medical condition which is identified within the Equality Act. Staff who are pregnant or on maternity leave are entitled to special considerations.

2 Purpose

2.1 The purpose of this policy is to describe a process which provides as early an opportunity as is practicable for all concerned to share a problem and explore the options available in a partnership approach. This should improve co-operation between managers, employees, trade unions and staff organisations, reduce uncertainty and lead to more proactive and informed decision making

3 Definitions

- **Organisational Change** - means any changes to working practices or contractual arrangements
- **Transfer of Undertakings and Protection of Employment (TUPE)** – Where the requirement for services of either a whole or part of a service is transferred to/from another organisation
- **Varying Terms and Conditions of Employment –** Proposed changes to an individual's terms and conditions of employment which include pay rates, hours or days worked, duties, or, where applicable, place of work.
- **Basic salary** - is exclusively the monthly sum due in respect of basic hours worked by an employee within the standard working week as defined in their terms and conditions of service.
- **Downgrading** – when an employee moves to a post in a lower band
- **Pay Protection** - where an employee takes up a new post, at a lower band, due to organisational change and their pay is protected for a time limited period (refer to Trust's Pay Protection Policy E23)
- **Reckonable service** - an employee's continuous previous service with any NHS employer counts as reckonable service (Section 12 of NH Terms and Conditions of Service)
- **Redundancy** – where a job role ceases as a result of organisational change
- **At Risk** - at the latter stages of consultation, where an individual has been identified as whether they have been slotted into a post in a new structure or if not whether they will need to be placed 'at risk of redundancy'.

- **Ring-fenced** – where displaced staff within the area affected by change are given the opportunity to apply for new posts within the new structure, before allowing staff outside of the area to apply.

4 Roles and Responsibilities

4.1 Chief Executive

4.1.1 The Chief Executive has overarching responsibility for ensuring the content of this policy is applied consistently and fairly across Alder Hey Children's NHS Foundation Trust.

4.2 Director of Human Resources and Organisational Development

4.2.1 The Director of Human Resources and Organisational Development is the named officer responsible for ensuring the content of this policy is applied fairly and consistently across Alder Hey Children's NHS Foundation Trust.

4.3 Executive Team / Division Board

4.3.1 The Executive team / Division Board are responsible for approving any proposals for organisational change with significant impact and overseeing the process.

4.4 HR Department

4.4.1 The HR Department is responsible for providing accurate and timely advice to managers and employees to ensure the policy is appropriately utilised across Alder Hey Children's NHS Foundation Trust.

4.5 Associate Chief Operating Officer / Service Managers

4.5.1 The Associate Chief of Operations / Operational Managers are responsible for:

- Considering the impact this policy may have on restructures or redesign of teams and departments within their service.
- Overseeing the dissemination of implementation of this policy across their service at any time when organisational change may impact on employees.
- Drafting a paper outlining the changes, which will include an equality analysis, to be approved by the Executive Team or Division Board (where required). They should provide periodic updates to the Executive Team or Division Board on the progress made in relation to the organisational change process, highlighting any risks and/or success of the programme.
- Following each organisational change project, a full evaluation process should be undertaken to identify lessons learned and to share for future change programmes.

4.6 Line Managers

4.6.1 Line Managers / Team Leaders are responsible for the dissemination and implementation of this policy within their teams at any time where organisational change impacts the employees they are responsible for. They must:

- Treat employees fairly and consistently
- Keep employees informed at all times
- Provide information to employees and Staff Side representatives on any proposed
- changes to the workforce
- Ensure full consultation takes place
- Document changes and discussions undertaken
- Listen and respond appropriately to employees concerns
- Recruiting managers to regularly meet with employees during trial period for assessment during redeployment. Recruiting manager to liaise with HR during the trial period highlighting any concerns.
- Original line manager provide new recruited manager for the transfer of any personnel file for continuity.
- Management to liaise with HR in advance of staff approaching end of Fixed Term Contracts
- Provide appropriate support and training to employees affected by organisational change including referral to any support mechanisms (e.g. Team Prevent (OH), staff counselling services (Alder Centre).
- Ensure that staff who are absent from the workplace are kept informed in relation to the changes.

4.7 Employees

4.7.1 Employees should review the contents of this policy where organisational change poses an impact on their work as well as embracing any organisational change that will improve services to our patients, using their skills and knowledge to find innovative ways of delivering our service.

4.7.2 Employees are expected to engage with the process of organisational change, providing feedback to the management teams involved at the earliest possible opportunity using informal processes in the first instance. Formal processes should only be utilised where all informal processes have been exhausted.

4.7.3 Employees must:

- Attend any consultation meetings as requested
- Inform their line manager of any personal circumstances that may prevent them from adapting to the changes, either medical or otherwise
- Actively consider any amendments to their post or offers of redeployment
- Actively review vacancies internally and externally to the Trust.
- Liaise with line manager and Recruitment for any suitable vacancies.
- Inform managers of their preferences for redeployment and personal constraints for alternative employment to assist with redeployment

- When placed on the redeployment register they must access the NHS Jobs website on a regular basis to view information available in relation to adverts, job descriptions and person specifications of current vacancies

4.8 Staff Side / Trade Union Representatives

4.8.1 Staff Side/Trade Union representatives play an important role when implementing organisational change as they can provide representation and advise to employees through a difficult period of time. Staff representatives should be contacted for further information about what they can provide in this process (details can be found on the Trusts Intranet pages). In order that the changes are implemented effectively staff representatives may:

- Provide feedback on the views of the employees affected throughout the change process
- Raise matters of concern informally before raising concerns under any formal processes
- Make representation to the appropriate level of management on behalf of members.
- Attend joint consultation/negotiation meetings with management.
- Inform members about consultations or negotiations with management.
- Meet with other representatives, or with full-time officers, to discuss business of an employee relations nature between the Trust and members of the staff organisations concerned.
- Have interviews with, and on behalf of members, on matters such as general advice, guidance, grievance and disciplinary matters, concerning them and the Trust.

4.8.2 In addition to the above, staff who are not members of a recognised trade union will have the ability to provide feedback on change through their normal management communications arrangements and will be subject to collective agreements made on behalf of all staff.

5 Types of Organisational Change

5.1.1 The NHS is continually changing in order to improve service delivery. Therefore, organisational change can impact on the way we are required to work or how a service is delivered to patients. These changes may not always affect employees directly in relation to the terms and conditions of employment, but might affect working practices on a day-to-day basis. Each of these examples will have varying degrees of complexity in relation to the impact on staff and on how the organisation delivers our services. As an organisation we are committed to supporting employees through the process.

5.1.2 The impact of the changes will vary depending on the circumstances. Some examples are provided below:

- Service Redesign/Restructures
- Changes to Working Practices and Duties e.g. working at night,(where there is a change to terms and conditions)

- Changes to Terms and Conditions of Employment (this may include small scale practise changes or large scale changes)
- Decommissioning
- TUPE Transfers
- Redundancy

6 Procedure for Implementing Change

6.1 Business Case for Change

6.1.1 The responsible Manager must draft a paper (or business case) in association with the respective Human Resources Representative outlining the proposed changes. The Divisional/Corporate Senior Management will be responsible for the approval of any change programmes. The Manager will be required to provide periodic updates for consideration highlighting any risk and/or success of the change programme. Within the Business case/draft paper, managers should identify if any new posts are to be evaluated within the appropriate and relevant job evaluation scheme (e.g. Agenda for Change Job Evaluation scheme). At this stage, an equality assessment template (EAT) will be initiated. Along with this, a Quality Impact Assessment must be completed at the point of management writing the business case.

6.2 Consultation Process - Guidance and Principles

6.2.1 In all cases, the Trust will allow sufficient time for meaningful consultation with staff and their representatives. In exceptional circumstances where changes need to be made very quickly, Trade Unions will be briefed immediately, and the verbal briefing will be followed by a written brief.

6.2.2 In a collective redundancy scenario, consultation will continue for a period of no less than the statutory time scales as set out within the Trade Union and Labour Relations (Consolidation) Act 1992. Therefore, where the Trust is proposing to consult with or dismiss as redundant up to and including 99 employees, then it will consult for at least 30 days and if the proposals concerns 100 or more staff, that period becomes 45 days. Alder Hey will continue to follow the statutory minimum consultation periods, however the Trust is committed to ensuring meaningful consultation takes place, and with prior agreement (given the complexity and numbers of staff affected) may increase a consultation period beyond the specific period identified in an individual organisational change process.

6.2.3 The process steps outlined below should be used as guidance on managing change; however it is important to note that effective consultation can follow various formats and the most appropriate process should be established following a discussion with the Human Resources Department.

6.2.4 Managers should seek to commence consultation as early as practicable and discussions should commence early enough to allow for meaningful consultation to take place, but at a point where the basic aims of the change are clear. Trade Union representatives will be entitled to a reasonable

amount of information as soon as possible, such as the reasons for changes and the proposed timescale as well as the number and type of staff affected.

6.2.5 Managers should develop an organisational change consultation document (see **Manager's Toolkit**), which outlines proposed changes, timescales and the processes to be followed.

6.2.6 Proposed changes should be shared with Trade Union Representatives prior to commencement of consultation with staff, where appropriate (e.g.: at the JCNC or Joint Staff Side Meetings) by issuing an advance copy of the organisational change document

6.2.7 The manager should arrange for a group meeting with all staff affected to inform them of the proposed changes and distribute the management proposal (at least seven calendar days prior to the meeting). At the meeting the management proposal should be fully explained. The meeting will be an information giving exercise and staff and their representatives will not be required to give feedback at this point. However, any points for clarification should be addressed. The manager should invite written feedback or alternative proposals within the timescales detailed for the consultation process. This can be on an individual or group basis or via their Trade Union. A record of verbal/written feedback of individual and group meetings should be kept and continuation of what has been discussed sent to all staff affected by the change.

6.2.8 Staff should be offered the opportunity to have group meetings/a one to one meeting with their Line Manager to allow them to express their views, discuss any concerns about the proposed changes along with their ability to adapt to those changes and identify any preferences in relation to future employment. Employees are entitled to be accompanied by a work place colleague or Trade Union representative, although it is acknowledged that this will not always be practical. Line Managers should take an open and honest approach to communicating with employees and ensure that they are kept informed at all times.

6.2.9 Managers should incorporate feedback from staff into the change management process where possible. For future reference, a record should be kept of any changes made to the proposals and the rationale/reasons for the change.

6.2.10 At the conclusion of the consultation process, a final management proposal will be distributed to staff and Trade Union representatives if any changes have been made to the original proposal. If necessary, further meetings may be arranged with staff and trade union representatives to clarify any outstanding issues, prior to the end of the consultation period. Records should be kept in the event of clarification being required at some future date

6.2.11 Any new posts will be required to go through the appropriate job evaluation process.

6.3 Individual Meetings (one to one's)

6.3.1 The aims of the meeting are:

- To ensure the individual is informed of the changes and understands how the change affects them
- Give the employee an opportunity to express any concerns or issues in relation to the changes
- Explore any opportunities available to them
- Explain any processes that will be in place i.e. selection
- Discuss disabilities that have been disclosed and possible reasonable adjustments required if applicable

6.3.2 Employees should be invited to the meeting in writing and a copy of the one to one document should be provided to the employee following the meeting**.** The one to one meeting is not compulsory, although it is highly recommended that employees take up this offer. During the consultation period, both Management and employees can request further one to one meetings if either feel this is necessary. A template letter inviting employees to the meeting is available for managers in the **Managing Organisational Change Toolkit**.

6.4 Methods of Communication

Methods of communication around change may involve a combination of some of the following:

- Meeting with Staff side representatives
- Open forum events
- Presentations to groups of staff
- Discussions in meetings
- Specific team briefings
- Email
- Staff notices
- 1:1 meetings
- Newsletters

The Trust will fulfil its obligations as outlined in the Information and Consultation of Employees (ICE) Regulations April 2005.

6.5 Ring Fencing

6.5.1 Where the organisational change centres on a general staffing review within a Department/Care Group, in the first instance posts within the new structure will be **"ring fenced"** to displaced staff within the immediate area i.e. displaced staff within that area will be given the opportunity of an interview for new posts within the new structure, prior to allowing staff outside of the area of immediate restructuring to apply. The extent of the ring fencing will be subject to consultation with staff side.

6.6 Matching People to Posts

6.6.1 Where there is no requirement to reduce staff numbers and/or where the substantive duties, band, hours of work, salary and other terms and conditions of employment of the post holder are wholly or mainly the same, and where there are an equal or more numbers of posts in relation to potential post holders, employees will automatically be slotted into the new structure, however this will be subject to consultation by management.

6.6.2 Line managers will be required to inform all employees, in writing, whether they have been slotted into one of the posts on the new structure, or whether they have been identified for redeployment.

6.7 Slotting-In Process

6.7.1 Employees will be slotted into posts on the basis of where their current duties are on the new structure. Therefore, if their duties are moved into another post and the post is of the same band, then they will be entitled to that post and be 'slotted in', providing that the number of employees is equal to the number of posts. If an individual's duties are split across two posts, which are of the same band, then the individual will be asked to state their preference and the line manager will be required to make a decision as to which post will be most appropriate to their experience and skills.

6.7.2 The assessment of slotting in individuals into posts will be completed through the 1:1 meetings. The final decision will rest with the line manager following the conclusion of the consultation, and after due consideration of any comments or proposals made.

6.8 When there are more employees than available Posts

6.8.1 Where it has been identified that there are more employees than available posts, consultation will take place to consider what steps can be taken to avoid redundancies (see Section 9.2 below). These steps will include the following:

- a review of overtime being worked;
- the introduction of restrictions on recruitment;
- a review of the use being made of contract staff (i.e. those on bank or agency);
- the consideration of any employees who are approaching retirement age and wish to consider early retirement;
- the possibility of redeploying and/or retraining people who are likely to be affected.

6.8.2 From time to time, dependent upon the financial circumstances, the Trust may undertake voluntary severance schemes such as the MAS (Mutually Agreed Severance) Scheme. If in operation, this scheme may be considered as an option and is completely voluntary. In addition, voluntary redundancy schemes may also be offered to staff to avoid compulsory redundancy situations where possible. Employees on fixed term contracts

will be reviewed on a case by case basis, in conjunction with senior HR support.

6.8.3 Where there remains a surplus of staff, after a full review has been conducted, there will be a process of competitive interview (or an alternative process) and selection into posts in the new structure against a predetermined criteria. Although not exhaustive, this may include assessment centres, competency based interviews, Psychometric testing, focus groups and CPD records. A detailed consultation document will outline a timeline for such processes and relevant assessment measures.

6.8.4 The responsibility for determining the pool of employees affected and fair selection criteria for identifying them as suitable for redeployment rests with management in consultation with Staff Side representatives. The criteria should be fair and objective (taking into account the requirements of The Equality Act 2010 and protected characteristics) and the needs of the service should be balanced with the wishes of the employees concerned. In particular, the aim should be to ensure that the essential and desirable expertise that exists within the organisation is retained.

6.8.5 The pool of employees will be restricted to employees at the equivalent banding of the posts concerned and are substantively based within the service affected by the change.

6.9 Staff who are Pregnant or on Maternity leave and affected by Organisational Change

6.9.1 Staff that are pregnant or on maternity leave, and are affected by organisational change, are entitled to special considerations to ensure they are not disadvantaged or discriminated against. Failure to consult a member of staff on maternity leave is unlawful. In redundancy situations, a suitable alternative position should be offered to the member of staff if a position is available. If, as part of the organisational change process, an interview or assessment process is required, reasonable steps should be taken, i.e. give sufficient notice, ensure the staff member is aware of developments at work, consider alternative venues for the process to occur, consider previous interview processes if within a reasonable amount of time.

6.9.2 Where an employee is on maternity leave and has been displaced they will have a statutory right to be protected and return to a post, where available Employees on maternity leave will be prioritised in accordance with their protected status under the Equality Act 2010 and given priority when a suitable alternative post becomes available.

6.9.3 If an employee does not meet the essential criteria of the person specification, or applies and fails to secure a post at the equivalent level in the new structure, then they may apply to be considered for other posts in the structure or other equivalent level posts within the Trust, provided this does not have the effect of unfairly displacing other employees.

6.10 Employees absent from work through Sickness Absence and/or Maternity Leave

6.10.1 Employees who are absent from work through sickness absence/maternity leave, will be encouraged to attend any meetings in the workplace, however, if the employee is unable to attend then the Line Manager should arrange to meet with the employee separately to ensure that they are kept informed of the process and how it affects them.

7 Redeployment / Vacancy Management

7.1 Introduction

7.1.1 The Human Resources Department will maintain a register of employees who have been identified as 'at risk' and suitable for redeployment. Employees will be notified of this. The register will contain information on the individuals' skill set and personal information for redeployment in addition to basic personal information.

7.1.2 Employees on the 'at risk' register will be provided with regular Trust vacancy listings during the period of their notice. An interview is guaranteed if the essential requirements in the person specification of an available post are met, or could be met with reasonable training. If successful at that stage, a period of a 4 week trial would be arranged, with no guarantee of appointment. This will be subject to both the agreement of the individual staff member and the recruiting manager.

7.1.2 Employees who unreasonably refuse to accept or apply for a suitable alternative post may forego their rights to any redundancy payment. Employees who seek redeployment through not being able to adapt to the changes i.e. a change in hours, where there is still a substantive role available will not be entitled to a redundancy payment.

7.1.3 As part of the Redeployment processes managers are required to hold 'one to one' discussions with their members of staff to explore alternative roles and should support and agree reasonable time off with pay to attend other interviews or related training (see 9.4.1 below). Staff should meet with managers to identify any development needs; actively consider suitable alternative positions and make themselves available for interviews or retraining, where applicable.

7.1.4 Provided that they meet the essential criteria for the post, or with training and/or experience, likely to within a reasonable timescale and are medically fit to undertake the role, they will be offered the post on a 4 week trial basis, which allows time for both the staff member and manager to ascertain their appropriateness for role. If there is more than one candidate in this position that meets the criteria and is able to undertake the position, a selection process will need to be applied.

7.2 Interviews for Alternative Posts

7.2.1 A selection interview is guaranteed whenever an employee on the register meets the essential requirements/criteria outlined in the person specification/job description of an available post or could do so with reasonable training. Employees will be interviewed against the person specification and the most suitable candidate from those who fulfil the requirements of the person specification will be offered the role.

7.3 Redeployment Register

7.3.1 The process for managing the redeployment register is outlined in the Redeployment Flow Chart in the Managing Organisational Change Toolkit.

7.4 Identifying Preferences for Redeployment

7.4.1 In considering redeployment, employees who have been identified as suitable for redeployment, should have a one to one with their line manager to establish:

- The degree of flexibility and personal aspirations
- Transferable skills
- The ability to work any other hours at other locations
- Options for alternative employment
- Personal constraints

7.5 Suitable Alternative Employment

7.5.1 When an employee or group of employees are identified as being suitable for redeployment, all efforts will be made to find suitable alternative employment within the Trust, based on skill set.

7.5.2 Suitable alternative employment will be defined in terms of pay, working hours, status, band, location and working environment. In considering whether a post is deemed as a suitable alternative, regard should be made to the personal circumstances of the employee, though employees will be expected to show flexibility by adapting their domestic arrangements where possible.

7.5.3 Suitable alternative employment will only be deemed appropriate where the employee secures a post at either the same band as their substantive post or one band below. Where suitable alternative employment is deemed appropriate at a lower band (one band below) then pay protection will apply. In such circumstances, if a member of the NHS pensions scheme, the individual member of staff should refer to the Pensions Agency for information relating to the protection of pensions benefits.

7.5.4 If an employee secures a post at more than one band below their substantive role then this will not be deemed as a suitable alternative and pay protection arrangements will not apply.

7.5.5 No individuals should gain promotion through the redeployment process. Promotion may only be achieved through an appropriate selection / assessment process.

7.5.6 Any individual employee who is aggrieved by a decision as to the suitability of alternative employment should in the first instance raise this with their line manager. If, following this, they are still not satisfied with the response; they should raise their concerns following the Appeals Procedure as outlined in Section 13.

7.6 Trial Periods

7.6.1 A trial period is required if an offer of suitable alternative employment is made to an employee who would otherwise be made redundant or through incapability (health) to undertake their current role and the suitability of the post is not clear from the outset i.e. a post outside the immediate department. The trial period would be up to a maximum of four weeks. Trial period arrangements, including mechanisms for assessment and review should be agreed before the trial period begins. The employee will remain on the re-deployment register for the duration of the trial period and should continue to review vacancy listings.

7.6.2 If, during the trial period, the post is deemed unsuitable by either the recruiting manager or the employee, the employee will be re-added to the redeployment register for the remainder of their notice period (up to a maximum of 12 weeks in line with AFC Terms and conditions), but for one more time only, without forfeiting the right to any redundancy payments.

7.6.3 The terms of the trial period and the subsequent arrangements i.e. protection of pay will be confirmed in writing to the employee prior to commencement. In all cases, the employee will remain employed on his or her substantive terms and conditions of employment throughout the duration of the trial period.

7.6.4 If, after the trial period ends following a formal review by the manager and employee the offer of the new post will be confirmed in writing. If no suitable posts are identified for the employee then they will be formally confirmed as redundant.

7.7 Acting Up / Secondments

7.7.1 Where an employee has been seconded or acted up into another post for a period of time, on the date on which they are identified for redeployment, the banding and terms and conditions of service of their original substantive post will be used to determine offers of suitable alternative employment, should they be unable to return to their substantive post.

7.8 Temporary Contracts

7.8.1 Employees who are employed on a temporary contract who are identified suitable for redeployment as a result of organisational change will be treated

equally to employees who hold a permanent post within the organisation with the exception of their entitlement to pay protection.

7.8.2 Employees who secure a suitable alternative post through organisational change will maintain their temporary contractual status for the period of their contract of employment, when their employment will end. Temporary employees will not automatically be afforded permanent status as a result of the changes.

7.9 Fixed Term Contracts

7.9.1 Staff who are employed on fixed term contracts with a contract end date will normally, not be subject to the agreements of a collective redundancy arrangement.

7.9.2 Management are required to liaise with HR in advance of staff approaching end of Fixed Term Contracts to scope eligibility dependant on staff continuous service.

8 Voluntary Redundancy or Early Retirement

8.1 Appropriate staff may be asked if they wish to be considered for voluntary redundancy in accordance with Agenda for Change Guidelines. If staff do express an interest in voluntary redundancy, the decision as to whether or not this is offered will be entirely at the Trust's discretion and at no cost to the Trust. As a rule this would mean that savings from the redundant post can be made within a two year period following redundancy/early retirement. The Trust will also need to ensure that the balance of the workforce in terms of experience and skills is maintained.

8.2 If staff express an interest in voluntary early retirement (with reductions) they can do this at any time, as long as they meet the requirements of the NHS Pension Scheme[1]. Full details of the financial implications and arrangements should be provided in writing and employees given sufficient time to consider this information before they are required to confirm their interest.

9 Redundancy

9.1 Introduction

9.1.1 The Employment Rights Act 1996 defines a redundancy as follows:

If the ending of an individual's employment is wholly or mainly as a result of one of two factors. They are:

- that the Trust has ceased or intends to cease carrying on the business or providing the service in which the individual was employed; or has ceased or intends to cease carrying on that business or providing that service in the place where the individual was employed; or

- that the requirements of the Trust for an individual to carry out work of a particular kind, or for an individual to carry out work of a particular kind in the place where the individual was employed has ceased or diminished or are expected to cease or diminish.

9.2 Measures to be taken for Minimising or Avoiding Redundancies

9.2.1 Wherever practicable all possible steps will be taken for minimising or avoiding redundancy as follows:

a) Forward planning of staff needs and recruitment plans as far ahead as is practicable
b) Reductions in overtime
c) Redeployment and retraining
d) Natural attrition
e) Non-renewal of temporary/fixed term employment contracts
f) Ensure all posts are advertised through the HR re-deployment register (if applicable)
g) Consider possibility of Mutually Agreed Severance (MAS)

In relation to c) above - redeployment and retraining - the following criteria below will be considered in deciding whether a post is suitable alternative employment, and whether it has been unreasonably refused:

1. Nature of the job/status
2. Qualifications and skills required
3. Career prospects
4. Hours and how worked
5. Travelling arrangements
6. Personal and/or domestic circumstances
7. Salary/Banding
8. Working environment

In relation to 6 above - personal and/or domestic circumstances - employees will be expected to show some flexibility by adapting their arrangements where possible.

9.3 Selection Methods for Determining Redundancies

9.3.1 Selection methods will be agreed locally according to the circumstances of the reduction, the staff groups involved and the requirements of the service following the change. Any or all of the following may be considered as criteria for selection, bearing in mind the requirement to ensure that the use of any criteria does not discriminate directly or indirectly on the grounds of disability, pregnancy, gender, gender reassignment, marital status, religion or belief, race, sex, sexual orientation or age.

1. Disciplinary records
2. Qualifications/Skills
3. *Attendance/Absence records
4. Records/Standard of work performance (documented)

**Where an employee has a medical condition that is identified within the Equality Act 2010, it may be necessary to make separate arrangements with the individual or make reasonable adjustments to take account of their circumstances. In addition, Maternity, Pregancy or Covid 19 related absence shall not count as absence for this purpose.*

9.4 Time off to look for work

9.4.1 Staff will be given reasonable time off, with pay and reimbursement of expenses, (if the post is within the Trust), to consult with management and staff representatives, to visit any new locations where they may be seeking alternative employment, to attend for interview and to attend training and retraining in accordance with the Trusts Travel & Subsistence Policy. Staff will be given reasonable paid time off to attend external interviews with other organisations/ NHS Trusts. Payment of expenses for external interviews is the responsibility of the recruiting organisation.

9.5 Training and Support

9.5.1 Appropriate preparatory training, induction and on or off-the-job training will be provided to enable staff to move into areas of work not fully covered by their original training or recent experience. This will include attendance at any courses or seminars that may be pertinent.

9.5.2 Reimbursement of any agreed travelling expenses should be in accordance with normal business travel as outlined in the Travel & Subsistence Policy.

9.5.3 In circumstances where staff are transferring into Alder Hey, consideration should be given to providing staff support prior to the date of the transfer. Other methods of support should be considered by Line Managers and where appropriate, access to career advice through external organisations such as Job Centre Plus.

9.5.4 Any employee who has been identified as suitable for redeployment will be given the opportunity through staff assistance / employability sessions to access information on personal finances including benefits / pensions as well as discussions about other employment or training opportunities.

9.6 Notice Periods

9.6.1 Contractual (or statutory notice, whichever is the greater) notice should normally be served to any staff involved in a redundancy situation.

9.7 Early Release of Redundant Employees

9.7.1 Employees who have been notified of the termination of their employment on grounds of redundancy, and for whom no suitable alternative employment in the NHS is available, may, during the period of notice, obtain other employment outside the NHS.

9.7.2 If they wish to take this up before the period of notice of redundancy expires the employer will, unless there are compelling reasons to the contrary,

release such employees at their request on a mutually agreeable date. That date will become the revised date of redundancy for the purpose of calculating any entitlement to a redundancy payment under this agreement.

9.8 Redundancy Pay

9.8.1 Redundancy pay will be calculated in accordance with Section 16 of the NHS Terms and Conditions, other local contracts of employment and the NHS Pensions Agency.

9.8.2 Doctors, Dentists and very senior management contracts and other local contracts are not covered by the NHS Terms and Conditions Handbook. Where such staff are identified as suitable for redeployment/redundancy, further advice should be obtained from the Director of Human Resources and Organisational Development and the Medical Staffing Manager.

9.9 Re-engagement Following Redundancy

9.9.1 For NHS Terms and Conditions of Service purposes, NHS organisations are 'associated employers'. Therefore if a member of staff is made redundant and accepts and commences a new NHS post within four weeks of leaving the previous post, they are not entitled to redundancy pay under the regulations, in accordance with NHS Terms and Conditions.

10 Retirement for Reasons Relating to Organisational Change

10.1 Only where it is in the interests of the efficiency of the service, employees of the Trust who are made redundant and meet the criteria of the NHS Pension Scheme to retire on the grounds of organisational change may be entitled to an early award of their pension benefits, in accordance with regulations of the NHS Pensions Agency.

10.2 Employees who qualify may receive immediate payment of pension and lump sum dependent on their pensionable service and age. Staff will be able to receive advice and an estimate of their individual pension benefits upon request.

11 Transfer of Undertakings and Protection of Employment (TUPE)

11.1 Introduction

11.1.1 TUPE Transfers, as defined under the Transfer of Undertakings and Protection of Employment (TUPE) Regulations, can occur where there is a 'business transfer' or there has been a 'service provision change'. TUPE transfers can be complex situations and will be reviewed on a separate basis dependent upon its particular set of circumstances. Legal advice will always be sought in such situations.

11.1.2 Where a service provision is transferred in or out of the organisation, Alder Hey will abide by the TUPE Regulations which preserves employees' terms and conditions. Please see Managing Organisational Change Toolkit for

TUPE flowchart. 11.1.3 As defined under the Regulations a 'relevant transfer' is when:

- A business, undertaking or part of one is transferred from one employer to another as a going concern (a circumstance defined for the purposes of this guidance as a 'business transfer'). This can include cases where two organisations cease to exist and combine to form a third;

- When a client engages a contractor to do work on its behalf, or reassigns such a contractor – including bringing the work 'in-house' (a circumstance defined as a 'service provision change').

11.1.4 This means that employees employed by the previous employer (the 'transferor'), when the transfer takes effect, automatically become employees of the new employer (the 'transferee') maintaining their previous terms and conditions of employment.

11.2 Due Diligence

11.2.1 Under the TUPE Regulations, the transferor is obliged to notify the transferee, in writing, of any employee who is assigned to the organised grouping of resources that is the subject of the relevant transfer no later than 28 days prior to the transfer date. The information that must be given is set out in the 'employee liability information' checklist which is available in the Managing **Organisational Change Toolkit.** Failure to comply with this could result in financial penalties being incurred.

11.3 Process

11.3.6 Once a TUPE transfer has been identified it will be the line manager's responsibility to identify the group(s) of staff that are affected by the transfer. They will then be required to:

- Contact a HR representative to support the transfer process.
- Liaise with the transferee/transferor to establish who is affected.
- Communicate with the affected employees.
- Work in partnership with staff side on the proposed transfer.
- Inform affected employees who are transferring of any changes that are being proposed within a reasonable timescale.

11.3.1 Consultation with staff is essential to ensure that Alder Hey Trust abides by its obligations under the Regulations and provides a communication mechanism for staff who are affected. Staff side representatives should be informed of any employees affected by any proposed transfers as soon as possible. This might include employees who:

- will be transferred
- will not be transferred but whose jobs might be affected
- might be affected by the transfer

11.3.2 The Trust is required to inform staff of:

- the fact that a transfer is going to take place, approximately when and why
- the legal, economic and social implications of the transfer for the affected employees
- whether any measures, like reorganisation will be taken, and how the employees are likely to be affected.

11.3.3 Consultation must be carried out with the aim of coming to an agreement and provide information within good time.

11.3.4 Employees transferring into or out of the organisation will retain the following contractual rights:

- all previous terms and conditions of employment
- holiday entitlement accrued
- continuous service
- any collective agreements previously made

11.3.5 The TUPE regulations prevent employees from suffering a detriment to their contractual arrangements after the transfer. They also prevent any changes to an employee terms and conditions being made solely for reasons relating to the transfer that is not connected to an 'economic, technical or organisational reason'.

11.3.7 Non NHS Employees transferring into Alder Hey wishing to adopt NHS Terms and Conditions may do so, if they wish.

11.4 Pension Rights

11.4.1 Pensions are exempt from transferring under TUPE legislation however; NHS employees who transfer between NHS organisations will automatically retain their membership of the NHS Pension scheme and all attributable benefits.

11.4.2 Non-NHS employees who transfer into Alder Hey will have their pension rights earned up to the time of any transfer protected. On transferring to Alder Hey employees will have the right to adopt the NHS Pension scheme.

11.4.3 Employees who transfer out of Alder Hey to a non-NHS organisation will have the pension they have earned up to the time of any transfer protected.

11.4.4 Employees transferring out of Alder Hey to their new employer will have the right to be offered a Pension scheme in line with TUPE regulations.

12 Termination of Employment and re-engagement

12.1 It is always the Trusts intention to mutually agree organisational change. However, there may be some situations, when all other options have been exhausted in an attempt to satisfy all parties involved, where agreement has still not been reached. In these certain circumstances if there is a failure to reach mutual agreement to the changes following conclusion of the consultation period, the employee may be given notice of termination of their contract of employment and offered re-engagement on the new terms.

12.2 If the employee then refuses the offer of re-engagement, their contract of employment may be terminated. This course of action will only be taken following full consideration of the individual's ability to undertake the new terms and should only be considered following advice from an appropriate HR representative.

13 Appeals Procedure

13.1 Efforts should be made by all parties to resolve any issues informally before formal procedures are invoked. Employees who wish to raise concerns about the way that consultation or redeployment processes have been handled or if they feel they have been treated unfairly, must in the first instance raise this with their line manager. If following a discussion with their line manager they are still not satisfied then employees will have the right to appeal any decision made by management that affects their employment status or working arrangements.

13.2 The appeal should be sent to the Director of HR & Organisational Development within 10 calendar days of the decision stating the grounds for the appeal. The appeal will be considered by an appropriate Associate Chief of Operations or Operations Manager (see Appendix A of the **Toolkit for Appeal Hearing Protocol**).

13.3 Employees will only have the right to one appeal and the decision of the Appeal Hearing Manager will be final. The Grievance Policy and Procedure will not apply to circumstances covered under this policy.

13.4 Appeals against redundancy will be heard by a Trust Board panel. Any other appeals (e.g. appeal against downgrading, appeal that the process was carried out incorrectly/unfairly) will be heard by a more senior manager from a different Division / Business Area up to Associate Chief of Operations / Operational Manager level.

14 Staff Support

14.1 The Trust acknowledges that staff impacted by organisational change may need additional support throughout the process. The following services are available for staff to contact if they wish.

14.2 Occupational Health (Team Prevent).

The Occupational Health service for Alder Hey is provided by Team Prevent UK Ltd, who have a dedicated team of Occupational Health professionals based on site on the interim site to help protect and promote the health and wellbeing of staff in the workplace. For staff who want advice they should call 01327 810 271.

14.3 Staff Advisory Liaison Service (SALS)

An easy to access hub run by staff, for staff who need advice, guidance or support

- Email: staffadvice@alderhey.nhs.uk
- Call x4511
- Drop in to the SALS office on the mezzanine in the main hospital atrium (next door to the lecture theatre)

14.4 The Alder Centre

The Alder Centre provides a free confidential staff counselling service. This service is open to all staff across Alder Hey Children's NHS Foundation Trust. The service can be used for work, relationship or personal problems that may be affecting the individual's ability to cope with their work. All counsellors are independent of the organisation and follow strict professional rules that safeguard their identity and the content of the sessions.

Staff counselling is offered on a one to one basis over a limited number of sessions, usually 6 -8 sessions. Sessions are for 60 minutes.

Services are normally offered at the Alder Centre but we can, in certain circumstances, arrange for a Counsellor to meet with you at an alternative venue.

Staff can contact the centre between the hours of 9am and 5pm on Ext 2391, 0151 252 5391 or via the Occupational Health Service. Further details can be obtained from the Trusts intranet pages here.

14.5 Employee Assistance Programme – Care First

They are an independent provider of employee support services. Their service is free for all staff and can be contacted on their 24/7 helpline 0800 174319 or they offer online support. They can be contacted via their website www.carefirst-lifestyle.co.uk using our unique login details:
Username: alderhey
Password: employee

15 Monitoring

15.1 Monitoring will incorporate monthly HR dashboard reporting contained within Board and Corporate reporting processes and includes equality monitoring processes.

16 Further Information

References

- ACAS Code of Practice
- NHS Terms and Conditions of Service Handbook
- Trade Union and Labour Relations (Consolidation) Act 1992
- Employment Rights Act 1996
- Transfer of Undertakings (Protection of Employment) Regulations 2006
- Fixed Term Employee's (Prevention of Less Favourable Treatment) Regulations 2002

17 Equality Analysis

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form		
Policy Name	**E13 – Organisational Change Policy**	
Policy Overview	Applying a partnership approach, this policy helps to help ensure that employees are treated in a consistent, sympathetic, fair and reasonable manner during an organisational change process	
Relevant Changes (if any)	Click here to enter text.	
Equality Relevance Select LOW, MEDIUM or HIGH	MEDIUM	
If the policy is LOW relevance, you **MUST** state the reasons here.	Click here to enter text.	
Form completed on:	Date: 11/02/2021	
Form completed by:	Name: Alan Rigby	Job Title: HR Manager

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted. (use **Equality Relevance** to assess the impact on each protected characteristic)	Protected Characteristic	Mitigation
	Age ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
	Disability ☑ How: Click here to enter text.	The Policy addresses circumstances where employees may have a disability and encourages discussion regarding suitable adjustments.
	Gender reassignment ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
	Marriage & Civil Partnership ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
	Pregnancy or Maternity ☑ How: Click here to enter text.	Employees on maternity leave will be prioritised in accordance with their protected status under the

		Equality Act 2010 and given priority when a suitable alternative post becomes available
	Race ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
	Religion or Belief ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
	Sex ☑ How: Click here to enter text.	See response re: Pregnacy or Maternity.
	Sexual Orientation ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
	Human Rights (FREDA principles) ☑ How: Click here to enter text.	There is no perceived differential or detrimental impact.
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	Primarily all staff are affected, including managers, senior managers, staff side representatives and consequently to service users, patients and the wider community. Evidence considered: NHS Employers, ACAS, other NHS Trusts, HR Networks across the Northwest in relation to best practise guides, staff side representatives gave staff experiences, special interest groups (direct experience of application of previous policy by managers), CIPD research forums. Equality monitoring takes place as part of the Trusts overall equality monitoring processes	
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See **Gunning Principles** for public consultation requirements. **How has consultation influenced the policy?**	As part of this process, the HR Team engaged with staff side colleagues, managers, other NHS Trusts, HRM/HR Networks and expert groups, CIPD, ACAS, and its own legal advice in the development of this policy. Management will continue to monitor and review at Division and Board levels to ensure the aspects of this policy are applied consistently, achieves its aims and objectives and is fit for purpose. This policy has been developed in partnership with staff side colleagues, expert managers, HR and learning and development teams across the organisation, including the Disability and BAME staff Networks. All outputs have been included in the final proposal. All staff can access the policy via the Trusts intranet. Staff who have problems accessing this policy are directed to the HR department or their Trade Union representative who can provide a hard copy and talk them through the process. Equality monitoring takes place as part of the Trusts equality monitoring processes	
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	Maternity, Paternity, Adoption and Shared Parental Leave Policy Flexible Working Policy Grievance Policy Supporting Sickness Absence and Attendance Policy Retirement Policy	
Public Sector Equality Duty	a) Eliminate discrimination, harassment, victimisation etc The policy complies with the Equality Act 2010.	

Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	b) Advance equality of opportunity The policy complies with the Equality Act 2010.	
	c) Foster good relations The policy complies with the Equality Act 2010.	
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐ No discernible impact has been identified, however mechanisms for scrutiny and monitoring for further development are in place	
Monitoring Include details of how the equality impact will be monitored.	This policy will be reviewed again in three years time as per standard procedure unless legislative requirements or equality monitoring deem a sooner review.	
Review of Equality Analysis (if indicated)	Rationale for review: Click here to enter text.	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If **MEDIUM** or **HIGH r**elevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Alan Rigby	Job title: Click here to enter text.
Approval Committee:	Employment Policy Review Group	Date approved: 11/05/2021
Ratification Committee:	People and Wellbeing Committee	Date ratified: 18/05/2021
Person to Review Equality Analysis:	Name: Sharon Owen	Review Date: 18/05/2021
Comments:	Click here to enter text.	

Alder Hey Children's
NHS Foundation Trust

C47 – PRIVACY & DIGNITY POLICY

Version:	4.1
Name of ratifying committee	Clinical Quality Steering Group
Date ratified:	12/01/2020
Name of originator/author:	Jayne Guy, Ward Manager, Christine Murray, Advanced Nurse Practitioner
Name of approval committee:	Senior Nurses Forum
Date approved:	17/12/2020
Name of Executive Sponsor:	Chief Nurse
Key search words:	Privacy, dignity, C47
Date issued:	April 2024 (Extension)
Review date:	August 2024

Quick Reference Guide – Privacy & Dignity Policy

Privacy and dignity are central to ensuring the delivery of high-quality effective care. This policy sets out the importance of privacy and dignity and details the steps the Trust will take to ensure that the patients in our care receive the highest quality service.

Making sure that we understand the variety of issues which each patient, parent or carer may face is the responsibility of all staff and it is never more important than in respect of ensuring privacy and upholding dignity.

This policy sets out the principles and practices which all staff should adhere to. It gives practical advice and outlines steps which can be taken to help improve privacy and dignity for all patients in our care.

KEY POINTS

- Respect for privacy and dignity is a key approach in upholding principles of equality & diversity and protecting human rights.
- All children & families in hospital should receive a standard of care which incorporates privacy and dignity considerations
- Incorporating privacy and dignity in all aspects of care delivery will promote equality of opportunity and promote individual rights, irrespective of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, religion or belief, sex or sexual orientation.
- The policy is to promote expected standards and strategies as defined in Essence of Care 2010 – Benchmarks for Respect and Dignity and to meet delivery of related Equality Delivery System for the NHS outcomes.
- All wards and departments will participate in Observation of Care Audits to monitor the care environment.

Key Staff Responsibilities:

Line Managers

- To promote the policy and ensure that staff understand their responsibilities in relation to privacy and dignity.

Employees

- Act in accordance with policy
- Ensure that privacy & dignity and promoting well-being are integral parts of all stages of care delivery

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
4.1	April 2024	Jayne Guy	Current	Extension until August to allow benchmark review with other Trusts.
4	January 2021	Jayne Guy, Ward Manager, Christine Murray, Advanced Nurse Practitioner	Archived	
3.5	December 2020	Hannah Ainsworth	Archived	3 month extension
3.4	January 2020	Hannah Ainsworth	Archived	6 month extension. Executive approved.
3.3	March 2019	Hannah Ainsworth	Archived	
3.2	April 2018	Hannah Ainsworth	Archived	
3.1	February 2018	Hannah Ainsworth	Archived	
3	April 2015	Hannah Ainsworth	Archived	Extended for 3 months awaiting changes to Equality Analysis Policy
2	October 2014	Vivienne Mitchell	Archived	6 month review date set
Safeguarding Privacy & Dignity - C47				
1	April 2010	Dianne Topping	Archived	Includes Chaperoning Guidelines and Protected Mealtimes
Chaperoning Guidelines - C44				
0	February 2007	Moya Sutton	Archived	
Protected Mealtimes Policy - M17				
0	November 2005	Paul McDonald, Catering Manager	Archived	

Record of changes made to Privacy & Dignity Policy – Version 4			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Various	Various	Reviewed and updated throughout	Out of date

Contents

1 Introduction

1.1 Privacy is a key principle which underpins human dignity and remains a basic human right and the reasonable expectation of every person, therefore this should be an integral part of the delivery of patient centred care.

1.2 Dignity can be defined as being "worthy of respect" but also includes being of equal value and worth irrespective of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, religion or belief, sex or sexual orientation.

1.3 This policy has been drawn up to assist staff in maintaining standards for respecting a patient's privacy and dignity as an integral part of the delivery of patient centred care.

1.4 Respecting and enabling an individual's right to privacy and dignity is an essential part of professional practice and accepted as a right by patients, parents and carers. This has been reflected throughout this policy.

1.5 The Trust is also committed to deliver the expected outcomes as identified in the national Equality Delivery System 2 (EDS2) and meet the specific equality duties defined by the Equality Act 2010.

1.6 Aims of Policy

The aim of the policy is to ensure that all children and families nursed within the community or within a hospital setting receive a standard of care which incorporates their right as individuals in respect of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, religion or belief, sex or sexual orientation.

1.7 Objectives

i. The objectives of this policy are to enable staff to:-Promote expected standards and recommend strategies that enable good practice whilst embracing the fundamental aspects defined in the Essence of Care 2010 – Benchmarks for Respect and Dignity document and the Trust's Equality Delivery System.

ii. Develop a culture of equality and diversity, being open, honest respectful of people's age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, religion or belief, sex or sexual orientation in line with the Trust's Equality, Diversity and Human Rights Policy – E1.

iii. Ensure that issues relating to mixing of same sex groups of individuals and differing ages are included in decision making. See Delivering Same Sex Accommodation Guidance.

2 Purpose

2.1 To provide all staff with guidance to enable them to actively respect and promote an individual's right to privacy and dignity whilst in the care of Alder Hey Children's NHS Foundation Trust.

2.2 The Trust has a duty to ensure all staff adhere to the standards and principles reflected within the policy to maintain a quality service for all patients, parents and carers, and to ensure a patient's right to privacy and dignity is promoted at all times by staff, irrespective of role or purpose, and within resources available.

3 Definition

The term 'carer' will be used throughout the policy to refer to any person with parental responsibility for the patient, who is not a parent.

4 Duties

4.1 Trust

i. The Trust has a legal responsibility for meeting our Public Sector Equality Duties (General Duties) described by the Equality Act 2010. The Trust's response to this is outlined in our ongoing progress towards meeting the identified Equality Objectives for the Trust. This responsibility informs all aspects of this policy.

ii. Safeguarding privacy and dignity for all is a central part of delivering the Equality Duties and all Trust staff must be aware of this policy.

4.2 Line Managers

i. Ensure that all staff members are aware of this policy together with their individual role in protecting privacy and dignity and promoting the wellbeing of children and young people.

4.3 Employee

i. All health professionals and support staff working directly with children and young people should ensure that protecting privacy and dignity and promoting their wellbeing forms an integral part of all stages of care delivery.

5 Staff Awareness

5.1 All staff who are in direct contact with children and young people should take account of particular needs, for example, related to cultural background, disability, religion and belief practice, and ensure that all their patients are treated equally.

5.3 Staff should complete Equality and Diversity training, as appropriate to their role. See Equality, Diversity and Human Rights Policy – E1..

6 Monitoring

6.1 An annual Patient Profile Report will be submitted to the Clinical Quality Steering Group.

6.2 Observation of Care Audits will be conducted as part of the visible leadership process and monitored by the Divisional Management Teams.

6.2 Patient experience will be monitored by the Friends and Family Test.

7 Further Information

Equality Analysis (hyperlink)

References

Equality Act 2010

Positively Diverse, DoH

NHS Plan

NHS Performance Assessment Framework

National Standards Local Action – Health and Social Care Standards and Planning Framework DoH 2005-8

Essence of Care 2010

Delivering Same Sex Accommodation, NHS England and NHS Improvement, September 2019

NHS Estates, House Keeping Project (England)

NHS Constitution

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Code of professional conduct for the nurse. 3rd Ed. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1992.

United Kingdom Central Council for Nursing, Midwifery and Health visiting. Guidelines for professional practice. London: United Kingdom Central council for Nursing, Midwifery and Health visiting 1996.

University of Sheffield. School of Nursing and Midwifery. Dignity on the ward: promoting excellence in care: good practice in acute hospital care

Human Rights Act www.justice.gov.uk/whatwedo/humanrights.htm

Health Care Commission, England www.healthcarecommissioning.org.uk

Castledine G (2008) Guiding behaviour towards giving care with Dignity, British Journal of Nursing, 24th April, 17(8) p557

Essence of Care 2010 – Benchmarks for Respect and Dignity

Associated Policies

Chaperone Policy – C69
Recruitment & Selection Policy – E2
Data Protection and Confidentiality Policy – RM44
Information Governance Policy – M45
Freedom of Information Policy – M25
Grievance Policy – E7
Disciplinary Policy – E5
The Management of Incidents, including Serious Critical Incidents – RM2
Complaints and Concerns Policy – RM6
Infection Control and Notifiable Diseases Policy – C15
Transport Policy – M40
Equality, Diversity and Human Rights Policy – E1
Consent Policy – C7
Interpreter & Translation Policy – C16
Uniform Policy – M37

Appendix A - Guidelines for Patient Privacy and Dignity

The following guidelines set down standards to safeguard patient privacy and dignity to enable all patients, parents or carers to be treated fairly and with respect in accordance with their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, religion or belief, sex or sexual orientation.

1 Factor One - Attitudes and Behaviours

i. Patients, parents and carers should feel that they are important and respected throughout their care*

**Dignity is concerned with how people feel think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of self worth, in a way that is respectful of them as valued individuals.*

Staff must strive to live by Alder Hey Values

ii. Patients, parents and carers will be addressed by their preferred name and title with permission from the patient, parent or carer.

iii. On arrival, staff will introduce themselves by name. All patients, parents and carers will be greeted in a timely, welcoming and courteous manner and orientated to the area. Communication with patients, parents and carers should take place in a manner that respects their individuality, circumstances and situation;

iv. Patients will not be referred to by their condition during handovers or ward rounds or during general staff conversation. Staff will not 'label' patients by a generic term / diagnosis e.g. 'a psychiatric patient', 'the fractured neck of femur' or 'boarder'.

v. Principles of common courtesy will be upheld when facing / conversations with patients, parents and carers at all times.

vi. Staff will demonstrate positive, sensitive and empathetic attitudes to all patients, parents and carers at all times.

vii. In the event of a patient, parent or carer making either a verbal or written complaint, they must be reassured this will not affect the care provided to the patient.

viii. Behaviour exhibited by staff should be professional and remain so at all times (as defined in professional codes of conduct and hospital standards etc).

ix. Health professionals can be in a vulnerable position at some stages during consultation, examination, treatment or care. The process of chaperoning allows health professionals to safeguard themselves from any accusation by patients, parents or carers, of improper conduct. See Chaperone Policy.

x. If necessary, staff should be ready to set aside their own values and beliefs and adapt their approach in order to accommodate the values and beliefs of each individual patient, parent and carer.

xi. Staff may need to take 'managed risks' to accommodate requests by patients, parents and carers, especially in cases of terminal illness, and be prepared to use flexible or imaginative approaches to meet these needs. This may involve supporting patients, parents and carers with decisions that under normal circumstances would appear to be a risk but when the terminal illness of the patient or patient discharge request is taken into consideration, the risk is less relevant.

xii. It is important that staff see beyond the patient in the bed and as person who has a past, present and future, and who has a 'patchwork of life experiences' that makes that person an individual.

xiii. Staff must structure, implement and sustain protected times so patient meals are not interrupted by unnecessary activity, to create a quiet and relaxed atmosphere in which patients are afforded time to enjoy meals.

2 Factor Two - Personal World / Personal Identity

i. All staff will aim to develop a culture that actively encompasses respect, individual values, beliefs and personal relationships;*

**In care situations dignity may be promoted or diminished by: the physical environment; organisational culture; the attitudes and behaviour of the nursing team and others; and the way in which care activities are carried out. When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves.*

ii. Staff will consider the age range of patients when placing new patients on ward;

iii. Issues relating to gender (including transgender / other gender identities) and age should be considered when placing the patient. (Please see Appendix B)

iv. Requests by patients (or patient representatives on behalf of the patient) to be nursed by a member of the same gender / religion should be considered. When providing personal or intimate care, staff should actively seek the views of the patient / parent on offering a member of staff of the same gender.

v. Dress codes of all religions will be respected and honoured to the best of the Trust's ability; in accordance with the Trust's Uniform Policy.

vi. Staff will document cultural, spiritual, social and emotional need in nursing care plans or relevant documents. Personal and family relationships will be recorded in patient documentation;

vii. Staff will be aware of how to access interpreting services and services used to provide translation; making use of intranet resources: Interpreter and Translation Services

viii. Information whenever possible will be provided in the main language of the patient, parent or carer and a variety of formats to meet individual needs;

ix. Staff will have an awareness of spiritual/cultural diversities and these will be recorded in all patient documentation. Staff will be able to inform patients, parents and carers of all facilities available to them with regard to their spiritual, social and emotional needs supported by written information;

x. Consideration will be given to where patients sit to eat their meals, supporting the social aspect of mealtimes whilst respecting the preferences of the individual.

xi. Staff will advocate that patients, parents and carers will be offered informed choices in the care and treatments the patient receives.

xii. Staff will encourage patients, parents and carers to contribute and, where appropriate, participate in planning and delivering holistic care. The degree of involvement in providing care by parents and carers will be documented in care plans and reviewed regularly by the patient's named nurse / team;

xiii. Staff will ensure that privacy and dignity are respected and maintained during visiting times and those patients, parents and carers, family and friends are receptive to the needs of other patients within the ward environment.

3 Factor Three - Personal Boundaries and Space

i. Patients, parents and carers personal space will be actively promoted by all staff.

ii. Children and young people who are judged to be competent have the right to attend appointments or treatment on their own and for any related information not to be shared with parents or carers (see Consent Policy - C17)

iii. Children and young people who are judged to be competent have the right to give or withhold their consent to any intervention (see Consent Policy – C7). They also have the right to request that a trusted adult is present whilst any consultation, examination, treatment or care takes place. In the case of patients under the age of 16, this is usually considered to be the adult with parental responsibility.

iv. In order to safeguard and promote the wellbeing of all children and young people attending the Trust, patients can request for a parent, carer or member of staff to be present as a chaperone during consultation, examination, treatment of care. See Chaperone Policy.

v. Parent/carers have a right to request for an independent chaperone to be present with them during their child's consultation, examination, treatment or care. This should be offered, in particular where care of an intimate nature is being provided (see Chaperone Policy).

vi. Any acceptable personal contact (touch) requirements identified by the patient, parent or carers should be recorded in all relevant documentation e.g. gender differences in certain religions.

vii. Identification of patient's personal boundaries/limitations should be included in handovers to other staff e.g. language, hearing, sight and feeding difficulties.

viii. Privacy should be maintained at all times through the effective use of curtains, screens, walls, rooms, blankets, appropriate positioning of patient and appropriate clothing;*

**Dignity can be promoted or diminished by, the physical environment, the attitude and behaviour of nurse's and others, organisational culture and the way is care activities are carried out. Influencing to improve dignity requires that everyone considers place, people and process in the practice area.*

ix. Interruptions of any type (including answering telephone or bleeps) during patient examinations, protected meal times or telephone conversations must be discouraged.

x. Well maintained facilities (clean and lockable doors) should be available in all areas including segregated washing facilities for male and female with clear signage, whenever possible

xi. Provide an environment conducive to eating, that is welcoming, clean and tidy and suitably prepared before meal times.

xii. Staff will always ensure patients are appropriately dressed and covered to ensure that privacy, dignity and temperature is maintained, especially during transport around the facility. This includes using a hoist and when moving or handling a patient;

xiii. Staff will ensure the environment is appropriate by being clean, smoke and draught free; with lighting that is sensitive and room temperature suitable for all patients.

4 Factor Four - Communication with Patients, Parents and Carers

i. Staff will introduce themselves by name and role to patients, parents and carers.

ii. Staff will ensure communication between themselves and patients, parents and carers takes place in a manner which respects their individuality;

iii. Staff will assess all patients, parents and carers on their communication ability and need e.g. learning disability, hearing impaired. These will be recorded in the relevant documentation;

iv. Staff will demonstrate sensitivity and avoid raising their voice excessively to communicate with patients, parents and carers who are hard of hearing;

v. Staff will access or facilitate appropriate translation/interpretation/hearing devices for patients, parents and carers. See Interpreter and Translation Services.

vi. Pertinent important information and expressed needs will be recorded in patient documentation.

vii. Staff will provide information to patients, parents and carers in understandable terminology and repeat as necessary.

viii. Staff will ensure that whenever possible the patient, parent or carer will be included in all changes concerning their care and have an opportunity to participate. This includes details of their complete and final diagnosis on discharge.

ix. The patient, parent and carer presence will be acknowledged at all times.

x. Staff will take time to listen to patient, parent and carer choices, decisions and views will be recorded in relevant documentation;

xi. Staff should endeavour to keep noise in clinical areas to a minimum especially during daytime rest periods, mealtimes and at night. This includes appropriate wearing of soft footwear, lowering voices, not banging doors or leaving telephones unanswered.

xii. Consideration of others will be advised when using TV and telephone.

xiii. Staff should provide explanations when a service is not available and provide feedback on progress, e.g. delays with laboratory and other test results ,transport services and catering provision.

xiv. Staff should involve users (patients, parents and carers) to gain alternative perspectives when redesigning or changing a service.

5 Factor Five - Privacy of Patient – Confidentiality of Information

i. Staff should ensure that patient information held in the clinical area is confidential. Sharing information with other disciplines requires consent. Such consent should be documented in patient records. This may not apply in some cases for patients detained under the Mental Health Act.

ii. Care should be taken to safeguard verbal, written and electronic information, including patient files and eliminate opportunities for casual unauthorised access. All staff should have completed Information Governance training annually.

iii. Staff should adhere to all policies and procedures to safeguard patient information (see Data Protection and Confidentiality Policy – RM44, Information Governance Policy – M45.

iv. Patients, parents and carers will receive copies of their medical correspondence if they so wish, in accordance with Trust policy;

v. When undertaking handovers in patient areas staff will ensure that information is not overheard by other patients, parents and carers or visitors.

6 Factor Six - Privacy, Dignity and Modesty

i. Staff will ensure that patient care actively promotes privacy and dignity and protects their modesty.

ii. Staff will ensure that patients are protected from unwanted public view by means of curtains, screens, walls, clothes or covers. Some patients, parents and carers will request to have doors open. However, doors will be closed when delivering care unless a risk issue has been identified and other arrangements should be made.

iii. Staff will allow patients who are competent to do so to bath, shower and toilet themselves with minimal supervision and will be given adequate time to do so unless a risk issue has been identified. Hand washing will be provided at the bedside after use of a commode or bedpan.

iv. Prompt removal of used commodes, bedpans and urinals are essential to avoid patient embarrassment.

v. Staff will actively encourage patients to wear their own clothing while in hospital but ensure items will not cause offence to other patients, parents and carers and visitors, e.g. scanty nightwear. This will include the nightwear of the patients own parent or carer.

vi. Staff will ensure gowns fasten securely, provide extra cover and are available in a wide range of sizes including extra-large. Additional garments will be made available to cover the patient if necessary, e.g. when walking to the toilet.

vii. Staff should offer help without waiting to be asked, e.g. anticipate toileting needs/or respond promptly to requests to avoid embarrassment and distress for the patient.

viii. Staff will take measures to limit patient ‘fluid collection bags’ from public view whenever possible.

ix. Patients will have a choice of where to eat their meals within the physical constraints of the facility.

7 Standard Seven - Availability of an Area for Privacy

i. Staff will endeavour to provide an area that safely provides privacy and this includes some situations when tests, investigations and consultations either as an inpatient or outpatient are required. It is recognised that barriers may exist that restrict the provision of such an area, however efforts should be made to afford privacy at all times.

ii. Staff should handle clinical risk in relation to complete privacy e.g. potential breach of confidentiality recognised and acted on / staff and patient safety.

Appendix B – Eliminating Mixed Sex Accommodation[1]

For many children and young people, clinical need and age and stage of development may take precedence over gender considerations. Mixing of the sexes may be wholly reasonable, and even preferred. Washing and toilet facilities need not be designated as same-sex as long as they accommodate only one patient at a time, and can be locked by the patient (with an external override for emergency use only).

Staff must make sensible decisions for each patient. All reasonable steps should be taken to maintain the privacy and dignity of children and young people in mixed sex accommodation.

Staff must also consider the needs of patients with other gender identities, where disclosed. A discussion must take place with the patient and their family about the accommodation and personal care options available, and the patient's preferences should be met where possible and practical.

Parents

Parents are often encouraged to visit freely and stay overnight. This may mean that adults of the opposite sex share sleeping accommodation with children. Care should be taken to ensure this does not cause embarrassment or discomfort to patients.

Single or Mixed Sex Accommodation Requests

1. Priority of bed allocation must always be given to the clinical condition of the patient and infection control measures (see Isolation Policy – C17).

2. If a patient or their parents make a specific request for mixed or single sex accommodation then staff must attempt to accommodate this. Requests should be documented on meditech, including details of discussion with the patient / parent, and any actions taken. If a request for single sex accommodation cannot be met on clinical grounds, the reason must be documented, including details of any additional measures to maintain privacy and dignity throughout their stay.

3. Where a patient specifically requests mixed sex accommodation (for same age or cultural group for example) then preferences of other members in the mixed area must be considered, and specific requests accommodated, where possible.

4. If it is not possible to accommodate specific, clinically appropriate, requests for single sex accommodation, and additional measures to maintain privacy and dignity within a mixed sex environment cannot satisfy the patient's / parent's requirements, this should be reported as an incident on Ulysses under under Cause Group 'Breach Of Same Sex Accommodation Guidance.' All breaches recorded under this Cause Group are reported externally.

[1] Delivering Same Sex Accommodation, NHS England and NHS Improvement, September 2019

Alder Hey Children's
NHS Foundation Trust

E47 - REASONABLE ADJUSTMENTS POLICY

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1	March 2023	Gill Foden, Katie Jones, Julie Worthington, Kerry Turner, Jillian Jenkins, Tony Johnson, Jeanette Chamberlain, Angela Ditchfield	Current	Introduction of new policy

Record of changes made to Reasonable Adjustments Policy – Version 1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	New Policy written	Policy on Reasonable Adjustments needed within the Trust, agreed at JCNC

Contents

1 Introduction

Alder Hey Children's NHS Foundation Trust recognise that reasonable adjustments can be of significant benefit to support people in the world of work and support overall health and wellbeing. People who may benefit from reasonable adjustments include employees who consider themselves as or are identified as disabled, and those who have been identified as benefiting from reasonable adjustments as an outcome of an occupational health assessment.

The policy acts as an enabler of the Equality Act 2010, which protects individuals with a disability and covers areas including application forms, interview arrangements, aptitude or proficiency tests, job offers, terms of employment, promotion, transfer and training opportunities, dismissal, or redundancy, disciplinary and grievance. In addition, it places a legal obligation on organisations to provide reasonable adjustments as far as this is reasonably possible.

1.1 What Are Reasonable Adjustments?

A reasonable adjustment is a change or adaptation to the physical or working environment that has the effect of removing or minimising the impact of the individual's impairment in the workplace so that they can undertake their duties. As a result, people with a disability or condition, or are neuro divergent will have the same access to everything that is involved in doing and keeping a job as a non-disabled person.

Reasonable adjustments may be required when a disabled person applies for and is recruited to a post, when an employee becomes disabled or develops a long-term health condition, when the impact of an impairment or medical condition deteriorates for an employee, when there is a change to the workplace or employment arrangements, or when there is need for a disabled employee to undertake further training.

Approximately 10% of our employees have been identified as fit to work by the Trust's occupational health provider with adjustments in place. It is to the benefit of all that the Trust, as an employer, work with employees to support them, and to help find mutually beneficial arrangements, maximising staff retention and wellbeing, as well as supporting staff to remain in work, return to work following a period of long-term sickness absence, maintain service provision and seek promotion opportunities.

In recognition of this, and in line with organisational values, this policy outlines a range of options, linked to personal circumstances as well as to promote understanding. It highlights the need for recognition of the psychological impact being reflected in organisational policy and practice, as well as the physical impact, addressing any potential for occupational health provision and line manager support; and identifies where advice and support can be found. This policy also outlines the actions for managers and employees to maximise wellbeing.

This policy has been created in partnership with trade unions as a commitment to work to improve response to reasonable adjustments within Alder Hey. It recognises the potential impact on wellbeing at work and the risk of being unable to attract or losing quality staff who might otherwise have been retained. It seeks to raise awareness with managers and colleagues to ensure that employees receive a sympathetic, supportive, and compassionate response so that appropriate ways of support can be offered, in line with service need; and defines the needs of individuals in supporting this transition.

1.2 Equality, Diversity, and Inclusion Statement

The Equality Act 2010 (The Act) requires the Trust to make 'reasonable adjustments' where provision, criterion, function, practice, and/or physical, environmental conditions of features in premises occupied by the Trust, places a disabled person at a substantial disadvantage when compared with people who are not disabled.

The Trust is committed to promoting equality and embracing diversity in its performance as an employer and service provider. It will observe legal and performance requirements, embedding equality and diversity principles throughout its policies, procedures, and processes.

The Trust drives the design and implementation of policy documents that meet the diverse needs of our services, our workforce, and our communities. We will ensure that none are placed at a disadvantage over others. We will respect the requirements of the Equality Act 2010, providing equal opportunities for all.

The Trust will make reasonable adjustments to support any employee, however there may be occasions where, after consideration, a requested adjustment cannot be accommodated. In such circumstances, the request will not be considered as reasonable by the Trust.

This document has been reviewed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

Consideration will also be given, using Human Resource best practice and adherence to all relevant employment legislation. The intentions of the Trust will be to ensure that the different needs of different protected equality groups in their area are respected and supported. This applies to all the activities for which the Trust are responsible, including policy development, review, and implementation.

2 Duties and Responsibilities

2.1 Chief People Officer

- To ensure that the reasonable adjustments policy adheres to the principles in current employment and equality legislation so that the Trust meets its statutory employment duties.
- To promote the fair and consistent application of this policy and to monitor its implementation across the Trust.

2.2 Line Managers

- Should familiarise themselves with the content of this policy, their role within it and be aware of support available within the Trust.
- Encourage employees with a disability/long-term condition to declare their information, enabling Alder Hey to act upon requests for reasonable adjustments and help employees feel confident that they will be supported by the Trust.
- When notified an employee has a health condition and requires support, line managers should seek advice from Occupational Health, HR and the Equality, Diversity and Inclusion Lead.
- Have open discussions about reasonable adjustments, appreciating the personal nature of the conversation, and treating the discussion sensitively and professionally.
- Co-ordinate the implementation of reasonable adjustments following recommendations from Access to Work, Occupational Health, Health & Safety etc.
- Record all reasonable adjustments agreed, ensure actions are implemented and that all agreed reasonable adjustments are supported within the workplace.
- Ensure ongoing, open dialogue with the employee regarding reasonable adjustments, that risk assessments are regularly reviewed to ensure they remain appropriate.
- Consider if other team members may need to be informed especially if the adjustment involves change of work, hours or change in work location. This should be done in consultation with the employee concerned and conveyed in a sensitive manner, respecting the confidentiality of the individual.
- Reach out to HR for advice if the adjustments are not deemed to be reasonable in nature.

2.3 Employees

- Have a responsibility to understand that people with an impairment or long-term health condition that impacts upon their daily activities, may require reasonable adjustments from their employer. Such adjustments are intended to tackle discrimination and create equality in opportunity for disabled employees and are carefully designed so that they do not impact negatively on the work of other staff or the organisation.
- Should notify their line manager if they have additional needs and assist with the consideration of and implementation of reasonable adjustments as required.

- Should maintain appropriate, timely communication with their line manager if they believe they have developed an illness or condition that may fall within the boundaries of the Equality Act and reasonable adjustments may be required to support them to undertake their role. Refer to Employee Leaflet - Appendix B.
- Take personal responsibility to look after their health.
- Be open and honest in their conversations with line/department managers, a HR representative, SALS and the Occupational Health Service, as appropriate
- Ensure they contribute to a respectful and productive working environment.
- Be willing to help and support colleagues, being mindful of any reasonable adjustments in place.
- Attend occupational health appointments and complete risk assessments with their line manager to identify support.
- Ensure individual equality monitoring section on ESR is up to date.

2.4 Staff Advice and Liaison Service (SALS)

- Provide support to employees who approach the team in a safe and confidential manner.
- To offer a one door listening service available to anybody who works within the community of Alder Hey. There are no referral forms needed nor criteria to be able to access the service if people are currently working within the umbrella of the Alder Hey Community.
- Support with signposting and resources as well as tailored individual support when required.
- Provide a confidential, impartial service for all employees of Alder Hey Staff.

2.5 Occupational Health Service

- The service can be utilised to provide appropriate medical advice to support and enable reasonable adjustments to be made, as required, to enable employees to fulfil their role, in a safe, supportive manner.
- A discussion with a line/department manager will take place so that they can complete a referral into the service on an employee's behalf.

2.6 HR Business Partner Team

- Take proactive measures to encourage disclosure of reasonable adjustments agreed and the rationale behind decisions. This can be done through adopting positive publicity, environment and workplace culture, promotion of this policy and via the recruitment, interview, appointment, or other registration processes.
- Provide advice and guidance to employees and line managers alike on specific policies and practices to support with reasonable adjustments e.g., sickness management, organisational change etc. Also, to support managers if there are concerns that the adjustments are not deemed reasonable.

2.7 Equality, Diversity, and Inclusion Lead

- Seek the voice of staff with disabilities to inform on-going equality, diversity, and inclusion work in relation to making reasonable adjustments, and ensuring the needs of individuals are met and there is equity of access to Trust services.
- Ensure annual return of the Workforce Disability Equality Standard and any associated action plan is progressed in a timely and effective way.
- Provide the Trust leadership team with accurate and up-to-date information on the governance and compliance requirements in relation to disability.
- Extend active support for people with a disability as a protected characteristic, in partnership with Human Resources and Trade Union representatives as requested.

3 Reasonable Adjustments in Practice

The Equality Act does not provide employers with a complete list of adjustments as they will vary for each member of staff, depending on their experience of their impairment and the type of work they carry out. It is important not to make assumptions about the needs or capabilities of a person. Reasonable adjustments are dependent on the needs of the individual and the most important thing is for managers to ask the member of staff. Some examples are provided below (this list is not exhaustive), including those frequently considered, however each case must be considered on an individual basis, regarding suitability.

3.1 Examples of Reasonable Adjustments

Examples of reasonable adjustments are listed below. Managers must also seek advice from Occupational Health, HR, Health and Safety and Equality, Diversity and Inclusion, as applicable.

Mobility impairment (including dexterity impairments)

- Ramps
- Accessible lifts
- Handrails
- Height adjustable workstations
- Accessible computer keyboards
- Adapted office furniture
- Speech-recognition (speech-to-text) software

Hearing impairments

- Hearing loops
- Vibrating or visual alarms
- Live captioning
- Video phones
- Subtitling
- Access to BSL

Sight impairments

- Screen-magnification or screen-reading software
- Magnification software for Personal Digital Assistants (PDAs) and mobile phones
- Braille machines and printers
- Video magnifiers for reading printed material
- Contrasting work surfaces or trays
- Braille

Mental health conditions

- Flexible working arrangements (e.g. working from home, working part-time, change of start/finish times)
- Longer or more frequent breaks
- Partitioned area or private office to reduce noise/distractions
- Division of large projects into smaller tasks
- 'To-do' lists or checklists
- Regular meetings with supervisors

Learning disability

- Smartphones or PDAs to assist with memory and planning
- Task cards
- ‘To-do’ lists or checklists
- Screen-reading software
- Speech-to-text dictation software
- Provide different coloured paper
- Verbal instructions

Long-term or chronic health condition

- Air-conditioning
- Height-adjustable workstations
- Changes to lighting (e.g., increased natural light, removal of fluorescent lighting)
- Flexible working arrangements (e.g., working from home or working part-time)
- Progression planning may be required for degenerative conditions (e.g., car parks, ramps, lifts, or bathroom modifications)

Common workplace adjustments

- Allowing some flexibility in working hours, such as working part-time or starting and finishing later
- Moving to a different location (e.g., a site closer to their home, the ground floor or allowing them to work from home)
- Moving furniture, widening a doorway, or providing a ramp so that a person using a wheelchair or other mobility aid can get around comfortably and safely

- Redistributing some minor duties (not inherent requirements of a job) that the person finds difficult to do due to their health condition
- Allowing a person reasonable time off during working hours for rehabilitation, assessment, treatment (e.g., physiotherapy or psychotherapy appointments) or counselling. e.g., time for appointment plus half an hour to travel to and from the appointment
- Providing additional training, mentoring, supervision, and support
- Purchasing or modifying equipment, such as speech recognition software for someone with vision impairment, an amplified phone for a person who is hard of hearing, or a digital recorder for someone who finds it difficult to take written notes
- Making changes to tests and interviews so that a person with a health condition can demonstrate their ability to do the job
- Providing readers who will read out documents for someone with low vision or learning disability, providing technology solutions
- Transcribing or modifying instructions, e.g., accessing formats for written documentation/electronic documents
- Allowing the person to work in a private room if open-plan office is not ideal, if practical
- Allowing extra breaks for staff who suffer with fatigue
- Redeployment of an employee into a suitable alternative role (advice from Occupational Health and HR must be sought prior to this)
- Review and adjustment of the sickness absence triggers (advice from Occupational Health and HR must be sought prior to this)

3.2 Reasonable Adjustment Checklist

Long term reasonable adjustments need to be kept under review and be monitored using the Reasonable Adjustment Checklist - Appendix C.

The Reasonable Adjustment Checklist should be completed within three months of the disability being highlighted to management. It is a living document and should be reviewed regularly by both the employee and manager and amended as appropriate by either side. Expert advice from third parties, such as Occupational Health, Access to Work or Remploy may be needed before changes can be agreed and implemented.

The purpose of Checklist is to:

- Ensure that the employee and manager, have an accurate record of what has been agreed.
- Minimise the need to re-negotiate reasonable adjustments every time an employee changes jobs, is relocated or assigned a new manager within the organisation.
- Provide an employee and their line manager with the basis for discussion about reasonable adjustments during future meetings.

New line managers of employees with a Reasonable Adjustment Checklist should accept the adjustments outlined as reasonable and ensure that they continue to be implemented, wherever possible. The Checklist may need to be

reviewed and amended later, but this should not happen until both parties have worked together for a reasonable period of time.

3.3 Reasons Why People May Not Declare

New and existing employees may not declare they are disabled or that they have a long-term health condition. The line manager has a role in ensuring that employees feel supported and are therefore more open to declaring their needs. Reasons can include:

- They feel that they will not get a job, training, development, or promotion.
- Their impairment is hidden, and they feel embarrassed about bringing it up.
- It may be seen as trivial.
- Previous negative experiences in employment have left them worried about raising it.
- They may not like to ask for help or feel that they can manage and want to fit in.
- Fear of losing their job.
- They think that they will be received unsympathetically or be told to 'just get on with it'.
- Disability or long-term condition diagnosis during employment, rather than at the beginning of employment.

4 Reasonable Adjustments and the Law

The Health and Safety at Work Act (1974) The Act requires employers to ensure the health, safety and welfare of all employees. Under Management Regulations of this Act, employers are required to carry out risk assessments. This legislation is prioritised above the Equality Act (2010) as employers are not expected to place disabled and other staff at inappropriate risk.

The Equality Act (2010) The Act protects people from discrimination in the workplace because of 'protected characteristics' and includes both direct and indirect discrimination and harassment. The protected characteristics are:

- age
- disability
- gender reassignment
- marriage or civil partnership pregnancy and maternity
- race
- religion or belief
- gender
- sexual orientation

The duty places a legal obligation on the organisation to consider how it can positively contribute to a fairer society through paying due regard to eliminating unlawful discrimination, advancing equality of opportunity, and fostering good relations between people who share a 'protected characteristic' and those who do not.

This includes:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of others.

5 Impact

The need to implement reasonable adjustments can result in several different approaches being undertaken, dependent upon the individual circumstances.

5.1 Recruitment Process

Applicants and employees who classify themselves as disabled may be eligible to an interview if they meet the essential criteria for a role as detailed in the job description and person specification. Additional information is available in the Recruitment and Selection Policy.

The Trust ensures that their commitment to Equality, Diversity & Inclusion is clearly stated on recruitment adverts to advise people they can highlight individual needs as part of recruitment activity.

5.2 Temporary Redeployment

From time to time, there may be a need to seek temporary redeployment for the employee as the individual may be fit to work, but unable to undertake their substantive role for a short time. When such a need arises, the line manager must seek the advice of Occupational Health and HR in the first instance. Further advice can be sought from the Equality, Diversity and Inclusion Lead if required.

Where Occupational Health advice supports a temporary redeployment, the line manager is required to follow the steps outlined in Appendix A – Temporary Redeployment Flowchart.

A temporary redeployment will initially be considered for a period of 12 weeks, a shorter period can be arranged if applicable. Following the 12-week period:

- The individual may be able to return to their post therefore the redeployment case cease.
- The individual would benefit from the temporary redeployment being extended and this can be accommodated.
- Further consideration as to whether redeployment is required on a permanent basis will be required. Occupational Health advice must be sought in relation to permanent redeployment. Upon receipt of the Occupational Health advice, the line manager must consult with their HR Representative, after which a formal meeting will be required with the employee and their staff side representative or workplace colleague if they wish to be accompanied.

5.3 Existing Health Conditions and Disabilities

If a person has an existing condition, they may need time off for medical appointments or treatment for that condition. It may also be necessary to review any triggers for sickness activity as a reasonable adjustment. Managers are required to seek Occupational Health advice in such situations.

5.4 Other Possible Actions

There are a range of activities that individuals, teams, Divisions and Trust may consider including:

- Asking all employees on appointment if they have any additional needs and what they may be, rather than asking if a person has a disability. Providing an explanation of why they are being asked, who will be informed about the information, storage and how it will be used to trigger follow up support/adjustments.
- Providing on-going opportunities for disclosure through discussions and meetings e.g., 121, supervision etc between the employee and their line manager.
- The Trust Disability Network group.
- Projecting a clear welcoming message to the public and staff through a variety of ways including recruitment, Trust Annual Reports, website and using appropriate language in all written and pictorial materials.
- Signpost employees during induction and core mandatory training to key aspects of the policy in context of Equality & Human Rights awareness.

6 Support

Alder Hey Children's NHS Foundation Trust is committed to supporting and maximising the wellbeing of its workforce and the provision of fair, respectful, compassionate, and inclusive working environments for all. The reasonable adjustments policy is underpinned by the principles of a compassionate culture, offering support, and raising awareness. It aims to provide information and support for employees who are directly and indirectly affected.

The organisation has a positive attitude to reasonable adjustments and will work proactively to make working adjustments where possible, linked to service provision, as part of our commitment to employees. The Trust recognises that the reasonable adjustments is a very individual experience therefore different levels and types of support and adjustments may be needed.

Employees who are members of a trade union can access support and signposting from their staff side representative or directly from their recognised trade union. Employees can seek support from the Freedom to Speak Up Guardian (FTSU).

6.1 Signposting for Self Help

An employee can take active steps to support themselves, including:

- Apply to Access to Work.
- Discuss any difficulties faced with their line manager so they are aware of the challenges that maybe faced.
- Have a wellbeing discussion or a wellness action plan.
- Have a stress risk assessment
- Record and monitor their symptoms and/or severity to understand how individual wellbeing may be being affected and how to seek support.
- Consider a change in working hours or pattern or remote working, if applicable to your job role via our Flexible Working Policy
- Consider a reduction in travel, dialling into some meetings or holding virtual meetings instead of face-to-face, if applicable.
- Accessing the Cheshire and Merseyside Resilience Hub who have extensive resources and access to additional support.
- 'How are you feeling toolkit'.

Financial

- Apply
- support available on the Alder Hey Intranet Hub.
- Staff Networks

Accessing the Staff Advice and Liaison Service maybe useful for both employees and line managers to seek advice and support for any employee who may need reasonable adjustments. The service aims to treat staff as individuals and support them in a compassionate and confidential way.

6.2 Practical Support from Line Managers

When an employee shares issues that may result in the need for reasonable adjustments, managers should gain an understanding of what the employee is likely to need and use the information provided in this policy to help start a conversation about potential reasonable adjustments. Things to consider include:

- Ensure information is treated in the strictest confidence and is not shared further without the employee's consent.
- Listen to and gain an understanding of any concerns the employee has about their issues or symptoms, avoiding assumptions.
- Discuss timescales and leave requirements if raised as part of the discussion.
- Take account of individual and business needs and be supportive when dealing with requests for work flexibility or leave, being mindful of the importance of being supportive of attendance at appointments and the potential unpredictability of symptoms.
- If required, work with the employee to develop a support plan to identify the adjustments to the working arrangements needed.

- Provide dedicated time and quiet space for 1:1s; promote avenues of support, signposting and links to organisational resources including guidance, flexible working, special leave, use of annual leave, reduced hours, and any changes to the working environment that you can facilitate, as applicable.
- Where additional support is required, provide information on specific health and wellbeing services.
- Promote a culture and environment that values diversity, shows dignity, respect, fairness, and equality and not tolerate or express what may be considered 'workplace banter'.
- Support with a risk assessment to consider the specific needs of individuals.
- Consider a phased return after sick leave in line with the Support Sickness and Attendance policy, if supported by Occupational Health recommendations.
- Consider any changes impacting performance, attendance, or behaviour.
- Contact HR if there are any concerns regarding being able to make the suggested adjustments. i.e., if they are not deemed to be reasonable.

6.3 Access to Work

This is a government run programme to help overcome barriers that disabled people may come across when moving into or retaining employment. It is provided where the employee requires support or adaptations beyond those "reasonable adjustments" which an employer is legally obliged to provide. It is not there to duplicate funding available from other sources, it is a flexible programme that focuses on the needs of the individual.

Access to Work will fund a Vocational, Ergonomic and/or technology and equipment assessment of need for the employee that is undertaken by an appropriate impairment or medical specialist, and that recommends solutions to any potential barriers. In most cases, Access to Work will fund whole or part of these recommendations.

6.4 Workplace Mental Health Support Service - Remploy

This is a free confidential service, delivered by Remploy and funded by the Department for Work and Pensions is available to any employees with depression, anxiety, stress or other mental health issues affecting their work.

Specialist advisors provide:

- Tailored, work-focused mental health support for six months.
- Suitable coping strategies.
- A support plan to keep employees in or return to work.
- Ideas for workplace adjustments to help employees fulfil their role.
- Practical advice to support those with a mental health condition.

7 Confidentiality

Staff who are made aware of an individual's health condition(s) in confidence must:

- Maintain confidentiality.
- Advise the individual to discuss their needs with their line manager, or other departmental manager, drawing their attention to this policy and other appropriate documents.
- Advise the employee of other sources of support available (such as Staff Advice and Liaison Service (SALs), via staffadvice@alderhey.nhs.uk Occupational Health, Trade Unions, FTSUG or Professional Bodies, Staff Disability Network).
- A breach of confidentiality can only occur where the individual's own safety is at risk, where the safety of others is at risk, or where a failure to disclose may result in criminal activity.
- The Trust recognises in some situations, colleagues may become aware of an individual's situation that requires a reasonable adjustment to be made. Should this be the case, then the information must be treated as confidential and should not be shared more widely without the consent of the person concerned.

8 Monitoring

The approval / ratification committees have ongoing responsibility to agree the monitoring arrangements for the policy. This may be assured via the committee reporting schedule or other agreed mechanism.

9 Further Information

- CIPD Guidance on Reasonable adjustments (www.cipd.co.uk/knowledge/culture/well-being/reasonable adjustments)
- ACAS Reasonable adjustments at Work (www.acas.org.uk/reasonable adjustments)
- NHS Employers (www.nhsemployersorg/articles/reasonable adjustments-and-workplace)
- Flexible Working Policy
- Supporting Sickness and Attendance Policy
- Special Leave Policy
- Menopause Policy
- Recruitment and Selection Policy

Appendix A – Temporary Redeployment Flow Chart

Appendix B – Employee Leaflet

Do you need reasonable adjustments at work?

What you need to do….

You may need the Trust to make some adjustments for you in the workplace due to your disability or long-term health condition. These will help you do your job, and they are called ‘reasonable adjustments’.

These changes may be simple, fast, and easy, or more complex to make.

1. **I’ve just realised that I need reasonable adjustments in the workplace. What do I need to do first?**

In the first instance, you will need to speak to your line manager.

2. **What information will my line manager need from me?**

You need to be able to explain to your line manager why you need the adjustments you're asking for. You should tell them why it's difficult for you to do your job compared to someone without your disability.

3. **What happens then?**

Your line manager will consider the adjustments that you have requested and if they can be provided. You and/or your line manager may need to speak further with Human Resources, Occupational Health or the Trust Equality, Diversity & Inclusion Lead on how best to support you.

4. **Can a line manager or organisation refuse a request for reasonable adjustments?**

Adjustments are a legal right. However, the adjustments must be ‘reasonable’. What is considered as ‘reasonable’ depends on your situation. If you or your line manager are unsure, you can contact the Human Resources Department or the Equality, Diversity & Inclusion Manager.

5. **I find it a bit awkward starting the conversation about my situation, what can I do?**

It can be daunting or distressing to explain about a health condition to someone for the first time. The Trust has introduced a Health Passport to help start the conversation. This can be taken to a meeting between you and your line manager or emailed in advance for discussion.

6. **Do I have to use the Health Passport?**

No, these are not mandatory or binding, they are just a means to help clarify how we can support you.

7. I'm not sure what reasonable adjustments I need. Who can help me?

If you are unsure as to what adjustments are available or may be helpful, then you can contact **Access to Work.** They are a government body who can come to work and undertaken an assessment with you.

The application to Access to Work must come from you. Your line manager **cannot** contact them on your behalf.

IMPORTANT: Please note that you MUST let your line manager know that you have contacted Access to Work so that they are aware that they are attending on site. You will then need to discuss their suggestions with your line manager.

8. What paperwork do I need to complete?

Once you have identified the adjustments you need, you will need to complete the Reasonable Adjustment Checklist, Appendix C. Line managers, workplace structures and situations change, and it is important that any new line managers are aware of your needs to maintain your adjustments.

9. I know what I need and my line manager is happy to accommodate me. I don't need an assessment or OH, what do I do?

That's great, you just need to complete the Reasonable Adjustment Checklist, Appendix C and access your adjustments.

10. What if my needs change?

It is vital that both you and your line manager meet regularly to review your adjustments in case these need to be amended or reconsidered. Some adjustments don't work as well as they might and may need reconsideration. It is important to review the Reasonable Adjustment Checklist and note any changes that have been made.

11. If I need support with reasonable adjustments and need to speak to someone other than my line manager, who is available?

You should speak with your line manager in the first instance. However, you are able to contact Human Resources, Occupational Health, the Equality, Diversity & Inclusion Lead, Staff Support and Liaison Service, the Freedom to Speak Up Guardian and your Trade Union Representative (if you are a member) if you wish to.

EQUALITY MONITORING

It is helpful for us as an organisation to know how many of our staff have a disability, or a long-term health condition. This is so that we can work to better support staff. You can update your equality monitoring section on your ESR portal.

Appendix C – Reasonable Adjustments Checklist

Reasonable Adjustments Checklist			
Employee Name:		Manager's Name:	
Detail of long-term condition / disability			
When did this situation start? e.g., from birth		Anticipated end date (if applicable) e.g., operation will resolve situation, no end date – permanent situation	
How does this impact on work?			
Date of discussion		Review date agreed	
Action Plan			
Concern / Barrier identified	Impact on job role?	What adjustment would help?	Agreed actions

This agreement is private & confidential it should only be shared with new managers with the express consent of the employee. This agreement may be reviewed and amended as necessary with the agreement of both parties.

Signed and agreed by:-

Employee: Date:

Line Manager: Date:

Occupational Health Advisor: Date:
(If applicable)

Appendix D - Health Passport

Health Passport Template

Name:

Job Role:

This is your health passport, which you own and take with you as move through roles within the NHS. The passport is a place you can store information about a disability, long term health condition, mental health issue, or learning disability/difficulty.

How to use the passport

You can use the passport to tell a new line manager about your health and anything you have in the workplace which enables you to carry out your role. For example, this could be:

- different start and finish times
- regular breaks at work
- a specific seat at your desk
- modifications to your desk
- any appointments you regularly need to attend to stay well at work.

You own this passport. It should be held by yourself and your current line manager in the area you work in.

You can make changes to the information within the passport when you need to. These should be shared with your line manager, and then recorded on the back page of the passport.

Information about you

The passport has three sections:

- Things my manager should know about my disability or health condition.
- Things that help me to do my role.
- Things to avoid or that make my work more difficult.

In each section there is a space for you to provide this information, which will help your current and future managers understand quickly and clearly the best way to support you at work.

Note: Keep your passport up to date.

You can record any changes to your condition or to your working environment in the passport.

Add the date and sign it so both you and your manager can check that you have the latest version.

Last updated (date):

Passport owner (signed):

Manager (signed):

Section One - Things to know about my health condition or disability

Include any useful information you would like your line manager or future line managers to know, e.g.

- Any tasks you need help with or cannot do easily.
- Any tasks which may take longer for you to carry out.
- Any diagnosis you feel would be helpful for your manager to know about.
- Any information regarding medication or interventions that you feel are relevant to work.

Section Two - Things that help me do my role

Include information that helps you to access your role and makes your time at work easier. This could be reasonable adjustments you have had put in place to support you.

Time - what times of the day are you able to best work?

Space – what sort of space do you like working in?

Technology and equipment – what technology and equipment helps you at work?

Communicating at work – how do you like to be communicated with in the office and given tasks? For example, you may like to be emailed your work tasks to help you remember or prioritise.

Section Three - Things to avoid or that make my work more difficult

Use this space to say what makes your time at work difficult, such as specific shifts or not having access to specific working arrangements.

Time - what times of the day are you not able to work?

Space – what sort of space do you dislike working in?

Technology and equipment – what technology and equipment do you find difficult to use at work?

Communicating at work – how do you like to be communicated with in the office and given tasks? For example, you may like to be emailed your work tasks to help you remember or prioritise.

Initial Equality Impact Assessment (EIA) Form	
This section must be completed at the development stage i.e. before approval or ratification. For further support please refer to the Equality Impact Assessment (EIA) Policy on DMS.	
Part 1	
Name and Job Title of Responsible Person(s): Gill Foden, HR Business Partner and Angela Ditchfield, Equality, Diversity and Inclusion Lead	**Contact Number:** via Teams
Department(s): Human Resources	**Date of Assessment**: 27/02/2023
Name of the policy / procedure being assessed: Reasonable Adjustments Policy	
Is the policy new or existing? New ☑ Existing ☐ This is a new policy, created following an initial request from staff side reps.	
Who will be affected by the policy (*please tick all that apply*)? Staff ☑ Patients ☐ Visitors ☐ Public ☐ Primarily all staff and potential employees are affected by the policy, including managers, senior managers, staff side representatives and consequently to service users, patients and the wider community. Evidence considered: NHS Employers, ACAS, other NHS Trusts, HR Networks across the Northwest in relation to best practise guides, staff side representatives and managers gave staff experiences via PRG, CIPD research forums.	
How will these groups / key stakeholders be consulted with? Stakeholder engagement was undertaken through the Policy Review Group, attended by staff side reps, managers from across the trust, Freedom to Speak Up colleagues, SALS attendees and HR colleagues. As part of this process, the HR Team engaged with staff side colleagues, managers, other NHS Trusts, HRM/HR Networks and expert groups, CIPD, ACAS, and its own legal advice in the review of this policy. Following the introduction of the new policy, management will monitor and review at CBU and Board levels, implementation activity to ensure the aspects of this policy is applied consistency, achieves its original aims and objectives and is fit for purpose. This policy has been developed in partnership with staff side colleagues, expert managers and HR. All outputs have been included in the final proposal. All staff can access the policy via the Trusts intranet. Staff who have problems accessing this policy are directed to the HR department or their Trade Union representative who can provide a hard copy and talk them through the process. Equality monitoring takes place as part of the Trusts equality monitoring processes.	

What is the main purpose of the policy? This policy sets out the standards and approach for supporting staff and the organisation when instances of reasonable adjustments activity are required. Ensuring activity is undertaken in a fair, sensitive and supportive way, whilst at the same time recognising the needs of the service and individual needs. As well as supporting the user experience, it is intended to minimise risks, and align with best practice and employment legislation
What are the benefits of the policy and how will these be measured? Reasonable adjustments can be of significant benefit to support people in the world of work and support overall health and wellbeing. People who may benefit from reasonable adjustments include employees who consider themselves as or are identified as disabled, and those who have been identified as benefiting from reasonable adjustments as an outcome of an occupational health assessment. The policy acts as an enabler of the Equality Act 2010, which protects individuals with a disability and covers areas including application forms, interview arrangements, aptitude or proficiency tests, job offers, terms of employment, promotion, transfer and training opportunities, dismissal, or redundancy, disciplinary and grievance. In addition, it places a legal obligation on organisations to provide reasonable adjustments as far as this is reasonably possible. Equality monitoring takes place as part of the Trusts equality monitoring processes. Arrangements for continued monitoring and evaluating the implementation of this change and its impact on different groups (Division Board to identify and raise to board if appropriate). Continued communication via intranet, FAQ's, Newsletters and other appropriate communication channels, making information available to staff and other key stakeholders.
Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes ☑ No ☐ *If yes, please give brief details:* Flexible Working Policy, Supporting Sickness and Attendance Policy, Supporting Staff Policy, Special Leave Policy, Menopause Policy and Recruitment and Selection Policy.
What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please use the **Equality Relevance** guidance (see on DMS) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).* *Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)*

Protected Characteristic	Tick either positive, negative or no impact			Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact		
Age	☐	☐	☑		Due consideration has been given to the potential for discrimination, inequality or differential impact, as part of the review process for policy work. This will be further monitored to identify any trends and suitable action will take place to minimise or manage these issues. Equality monitoring takes place as part of the Trusts equality monitoring processes.
Sex	☑	☐	☐	See section 6 and 7 of the Policy	
Race	☐	☐	☑		
Religion or belief	☐	☐	☑		
Disability	☑	☐	☐	Refer to Section 1,3,5, 6, and Appendix B and C of the policy	
Sexual orientation	☐	☐	☑		
Pregnancy and maternity	☑	☐	☐	See section 6 and 7 of the Policy	
Gender reassignment	☐	☐	☑		
Marriage and civil partnership	☐	☐	☑		
Other (specify)	☐	☐	☐		

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)

This process of review and its subsequent implementation has been managed to ensure that there are equitable processes in place. An inclusive approach taken to consultation mechanisms which have enabled wider groups to understand change and its impact and to ensure no disadvantage between groups. No discernible impact has been identified however mechanisms for scrutiny and monitoring for further development are in place.

Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? Yes ☐ No ☑ *See **Equality Relevance** guidance (on DMS) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal).* Everyone has the right of respect for his private and family life, his home and his correspondence (Article 8). See section 2, 5 and 6 of the policy
If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form on DMS.

Action	Lead	Timescale	Review Date
N/A	N/A	N/A	N/A

Declaration	
I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:	Tick one box
Continue – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken	☑
Justify and continue – EIA has identified an adverse impact but it is felt the policy cannot be amended. ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***.	☐
Make Changes – EIA has identified a need amend the policy in order to remove barriers or to better promote equality ***You must ensure the policy has been amended before it can be ratified.***	☐
Stop – EIA has shown actual or potential unlawful discrimination and the policy has been removed	☐
Name: Gill Foden Date: 27/02/2023	

Approval & Ratification		
Policy Author:	Name: Gill Foden	Job title: HR Business Partner
Approval Committee:	Employment Policy Review Group	Date approved: 14/03/2023
Ratification Committee:	People and Wellbeing Committee	Date ratified: 29/03/2023
Person to Review Equality Analysis:	Name: Gill Foden	Review Date: 29/03/2026
Comments:		

Alder Hey Children's
NHS Foundation Trust

E24 – RESPECT AT WORK POLICY
(Incorporating Bullying and Harassment)

Version:	8.1
Name of ratifying committee:	People and Wellbeing Committee
Date ratified:	14/09/2020
Name of originator/author:	Sarah Marshall, Human Resources Manager
Name of approval committee:	Employment Policy Review Group
Date approved:	24/06/2020
Executive Sponsor:	Director of Human Resources
Key search words:	Bullying, harassment, respect, support, behaviours E24
Date issued:	August 2023 (Extension)
Review date:	May 2024

respect excellence innovation together openness

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
8.1	August 2023	Sarah Marshall	Current	Extension
8	September 2020	Sarah Marshall	Archived	Title updated
Bullying and Harassment Policy – E24				
7.2	April 2020	Sarah Marshall	Archived	Extension approved due to COVID-19 pressures
7.1	December 2019	Sarah Marshall	Archived	Extended for 6 months
7	January 2019	Sarah Marshall	Archived	
6.1	September 2018	Sarah Marshall	Archived	Extended pending review
6	October 2015	Neil Davies	Archived	Revised title and content within new template
Respect at Work Policy – E24				
5	February 2012	Jackie Waring	Archived	Revised to update responsibilities and to reflect Equality Act 2010
4	February 2011	Rachel Patterson	Archived	Minor revisions to reflect CBU Structure
3	September 2009	Dave Eaton	Archived	Renamed to Respect at Work
Bullying and Harassment Policy – E24				
2	October 2006	Dave Eaton	Archived	
1	April 2005	Jackie Waring	Archived	

Record of changes made to Bullying and Harassment Policy – Version 8.1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	Extension

Record of changes made to Bullying and Harassment Policy – Version 8			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	Al	Title changed from Bullying and Harassment to Respect at Work (incorporating Bullying and Harassment)	More positive

All	All	Completely re-written: • Much more emphasis on the informal stages and advocating that staff aim to try and resolve issues themselves. • Signposting staff to the many sources of support and guidance available. • Additional information/clarity on mediation and facilitated conversations, including when they are appropriate to be used and when they may not be. • Encourage staff to speak out and challenge negative behaviours, incivility, etc, if they receive it or observe it. • The Policy now only references what a formal investigation entails, and signposts the reader to the Trust Investigation Policy. • Additional tools/resources added to the toolkit. Empowering staff to resolve issues themselves, when appropriate. Civility Saves Lives explains and stats given.	Out of date

Contents

1. Introduction

1.1 The Trust is committed to ensuring that all complaints in relation to bullying and/or harassment will be taken seriously and investigated swiftly, thoroughly and confidentially with due respect for the dignity and rights of all those involved. Victimisation as a result of making a complaint will not be tolerated and disciplinary action will be taken if necessary.

1.2 The Trust is also aware that malicious allegations can cause lasting damage to an individual's reputation and career prospects. Therefore any allegation that is found to be malicious may ultimately be subject to action under the Trust's Disciplinary Procedure and in extreme cases result in dismissal.

1.3 The Trust recognises its duty to ensure that all employees are aware of this policy and their responsibilities related to it.

1.4 This policy outlines mechanisms designed to ensure that any allegations of bullying, harassment, or disrespectful behaviour(s) are dealt with promptly, seriously and sympathetically both towards the complainant and the person against whom the complaint is made.

2. Purpose

2.1 Policy Statement of Commitment

Bullying and harassment of any kind is not acceptable and will not be tolerated. The Trust is committed to ensuring a working environment free from all forms of bullying and harassment.

To this aim, the following principles outline measures in place which will help facilitate informal and formal resolution of concerns raised. Encouraging staff to raise concerns early on, as part of everyday practice will help with some of the difficulties they may experience, and to foster an open and transparent approach to dealing with some of the issues raised.

By focusing on improving workplace culture and dealing effectively with disrespectful behaviour whenever it arises, it is expected that instances of bullying and harassment will become much more isolated.

This commitment is also part of the Trusts values and behaviours, which is a fundamental part of the Trusts revised performance development review (PDR) process, the Trusts Raise it, Change it Campaign and the duty of candour contained within job roles.

2.2 To achieve this aim the Trust will:

Promote awareness of the Trust's position on this issue and reinforce the culture that bullying and harassment will not be tolerated from any member of staff, help foster a positive and dignified workplace culture and created an environment which is free of bullying and harassment.

- Ensure effective communication to all staff of this policy and individual responsibilities through Trust induction and other appropriate means of staff communication.

- Provide appropriate training for managers and supervisory staff to ensure they are equipped to deal with bullying and harassment issues.

- Provide a framework where members of staff who feel they are subject to bullying or harassment behaviours can seek appropriate support**.**

3. Definitions and Examples (also see Appendix A)

3.1 Harassment

- The Equality Act 2010 uses a single definition of harassment to cover protected characteristics: unwanted conduct related to a protected characteristic which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual.

- Harassment is identified by the effect that it has on the recipient, not by the intention or non-intention on the part of the alleged perpetrator.

- Employees are able to raise concerns regarding behaviour they find offensive even if it is not directed at them.

- Appropriate, constructive and fair criticism of an employee's performance or behaviour at work is not harassment.

Protected characteristics under harassment law are:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

Harassment can include:

- a serious one-off incident
- repeated behaviour
- spoken or written words, imagery, graffiti, gestures, mimicry, jokes, pranks, physical behaviour that affects the person.

The law on harassment also applies to:

- a person being harassed because they are thought to have a certain protected characteristic when they do not.
- a person being harassed because they're linked to someone with a certain protected characteristic.
- a person who witnesses harassment because of a protected characteristic and is upset by it.

3.2 Bullying / Disrespectful Behaviour(s)

Bullying / disrespectful behaviours are largely identified by the effect it has had on the individual who feels they have been subject to this kind of treatment, not necessarily by what has actually been done; it can be on an individual's perception. It can be defined as persistent, offensive, abusive, intimidating, malicious or insulting behaviour, or abuse or misuse of power which occurs repeatedly and regularly over a period of time which makes the recipient feel undermined, upset, threatened, humiliated and vulnerable. It can be described as a pattern of unwanted behaviour(s), which can undermine their self-confidence and possibly cause them to suffer distress.

3.3 Examples of Bullying and Harassment

Harassment and bullying can take many forms, ranging from extremes such as violence to less obvious forms such as ignoring someone. Examples of inappropriate / disrespectful behaviour could include:

- Verbal or physical threats or intimidation or unwanted physical contact
- Humiliating someone in front of others
- Unjustified and persistent criticism or negative comments, belittling someone's opinion
- Offensive or abusive personal remarks or insulting someone by word or behaviour
- Jokes, offensive language, gossip, slander, spreading malicious rumours, sectarian songs, letters, posters, graffiti, obscene gestures, flags, emblems
- Setting unattainable targets
- Constantly changing work targets in order to cause someone to fail or undervaluing work done
- Reducing someone's effectiveness by withholding information
- Ostracism, exclusion or victimisation
- Claiming credit for someone else's work
- Monitoring work unnecessarily and intrusively or imposing unfair sanctions
- Undermining someone's authority/responsibility or removing areas of responsibility without justification
- Isolation or non-co-operation and exclusion from social activities

- Offensive e-mail (flame mail)
- Coercion for sexual favours and pressure to participate in political/religious groups
- Intrusion by pestering spying and stalking

This list is not intended to be exclusive or exhaustive.

4. Duties and Responsibilities

Overall responsibility for ensuring this policy is implemented rests with the Trusts Board of Directors, with specific accountability with the Director of Human Resources and Organisational Development.

In addition, all patients, members of the public and individuals visiting the Trust from other organisations have a right to be treated with courtesy, dignity, fairness and respect at all times. However, they also have a responsibility for their own behaviour. The Trust will take action in the event of any inappropriate behaviour, which is observed or reported regardless of whether or not the complainant and/or alleged perpetrator is a Trust employee.

4.1 It is the role and responsibility of the **Trust Board** to, establish and maintain an environment free from disrespectful / inappropriate behaviours by:

- Lead by example, ensuring that each of its members is fully aware of his/her role under the policy
- Ensure managers are equipped to tackle incidents of bullying and harassment by providing resources for training and ongoing advice and support.
- Demonstrate the Trust Board's commitment by addressing any organisational factors which may lead to bullying and harassment.

4.2 It is the role and responsibility of **Management** to, establish and maintain an environment and culture free from disrespectful / inappropriate behaviours by:

- Taking prompt action to stop harassment and bullying, by pointing out that the behaviour is unacceptable, managers may be able to effectively to put a stop to the problem without the need for further formal action.
- Ensuring that all employees in their area of work are made aware of this policy, and that they have a right not to be harassed or bullied at work. All employees will be made aware that this behaviour is unacceptable and where appropriate, may be referred to the Disciplinary Policy.
- Setting a positive example by treating others with respect and setting standards of acceptable behaviour; also promote a working environment where harassment is unacceptable and not tolerated.
- Ensuring that offensive or potentially offensive material is not displayed in the workplace.

- Ensuring all complaints of harassment and bullying are treated seriously and sympathetically and with confidence by management.
- To create a respectful working environment where individual team member differences are recognised in a positive way.
- Ensuring that staff members understand that victimisation of any employee making or helping someone to make a complaint is unacceptable and where appropriate may be referred to the Disciplinary Policy.

4.3 **All staff** – all employees have a responsibility to:

- Be pro-active in promoting an atmosphere free from bullying or harassment across the Trust, and to challenge or report instances of bullying or harassment whenever it is witnessed.
- Where possible take control of their own situation by asking the offender to stop and/or making it clear that their behaviour is unacceptable or unwanted.
- Support other individuals who experience bullying or harassment
- Seek help when unsure of how to deal with a situation and when support or advice is required
- Treat fellow staff members, patients, members of the public and individuals from other organisations who are visiting the Trust with courtesy, dignity, fairness and respect at all times.
- Display the Trust Values and Behaviours at all times. See section 1.3, in Appendix A.

4.4 It is the role and responsibility of the **Human Resources Department / Equality and Diversity Manager** to:

- Assist and support the implementation of the Respect at Work Policy across the Trust
- Ensure collation and reporting employee relations activity data related to incidents of bullying and harassment or disrespectful behaviour
- Provide guidance, advice and support to managers and staff
- Encourage referral to the range of other support available in the Trust
- Where applicable, to contribute to the provision of training for managers and staff

4.5 **Accredited Trade Union Representatives** will:

- Work alongside managers, staff and HR in a supportive way to implement the policy and to ensure incidents of bullying and harassment are handled sensitively and fairly.

4.6 It is the role of the **People and Wellbeing Committee** to:

- Perform a pivotal role in ensuring that this policy is implemented.
- Oversee monitoring of the efficiency of the policy and other measures to reduce bullying and harassment in the workplace.
- Receive an annual report and monitor any action plans.

5. Effects of Bullying and Harassment / Disrespectful Behaviours

It is important to know the effects of bullying and harassment since the conduct itself may well go unnoticed for some time. Incidents may occur when no witnesses are present and recipients of such behaviour may not wish to inform anyone of the situation. Bullying and harassment may be very subtle and may not always be easily identifiable.

Allowing bullying and harassment to go unchecked or detected can result in:

- Employees being unable to work effectively if they feel under threat.
- Antagonism between people who should be working as a team feeling forced to take sides on the issue.
- Increasing absenteeism due to stress leading to the need for work to be covered by others, this in turn leads to stress on colleagues.
- Lack of confidence in the organisation.
- Reduced motivation and poor morale.
- High staff turnover.
- Litigation claims brought against the Trust for discrimination and personal injury.

6. General Principles

6.1 Raising / Reporting Concerns

As soon as disrespectful behaviour is recognised or witnessed, members of staff should feel able to make it clear that they are uncomfortable with such behaviour and to ask the person to stop. Staff should feel empowered to challenge the individual concerned in the knowledge that this challenge is justifiable and acceptable. Support is accessible; please see useful contacts (Appendix A, section 5). Equally it is understood that an individual may find it difficult to challenge the action of others and will need additional support.

Staff are encouraged to keep a written record of events of any incidents, including what happened, when it occurred, together with the names of any witnesses.

Staff can also raise concerns through the Trust **Freedom to Speak Up Champions / Guardian (FTSU),** line manager, HR Department, trade unions / staffside. Refer to the Respect at Work Toolkit for further details.

6.2 Witnessing Inappropriate and/or Disrespectful Behaviour

If a member of staff witnesses a fellow employee being bullied or harassed they are strongly advised to help. Offering support to someone who is being bullied or harassed could encourage them to report it. If the case was particularly serious the staff member will need to report what they witnessed to responsible person such as their line manager, a Human Resources department or the Equality and Diversity Manager.

It is recognised widely that a difference can be seen between a firm but fair management / leadership practices to that of a manager with a management style that is perceived as bullying by staff. The table below sets out a framework to make clear the distinctions between the management styles and provides a guide as to whether a member of staff's concerns may relate to bullying. These behaviours apply to staff at all levels, throughout the Trust.

Firm but fair Behaviours from Management	**Bullying / disrespectful or harassing / inappropriate behaviors**
Consistent and fair	Aggressive, inconsistent and unfair
Asks for people's views and listens to the team	Tells people what is happening, does not listen
Determined to achieve the best results but reasonable and flexible	Unreasonable and inflexible
Knows their own mind and is clear about their ideas, but willing to consult with colleagues and staff before drawing up proposals	Believes that they are always right, has fixed opinions, believes they know best and not prepared to value other people's opinions
Insists on high standards of service and behaviours in the team	Insists upon high standards of service and behaviour but blames others if things go wrong
Will discuss in private any perceived deterioration before forming views or taking action and does not apportion blame on others when things go wrong	Loses temper, regularly degrades people in front of others, and threatens official warning without listening to any explanation

7. Process for Raising / Reporting Concerns

7.1 Informal Approaches – please see Appendix B for Pathway.

An informal approach is generally considered the best approach and should be given very serious consideration in the first instance. A person may be unaware of the effect their behaviour has on others, many incidents of bullying or harassment will be more effectively dealt with in an informal way. Moreover, an informal process will always be less destructive and damaging to relationships and less stressful for all those involved.

Trade unions also support this approach and it is seen as an example of best practice by The Advisory, Conciliation and Arbitration Service (ACAS).

A member of staff who feels they are subject to disrespectful or inappropriate behaviours should, where possible and appropriate, make the alleged bully or harasser aware that their behaviour is unacceptable and must stop. This may be verbally or in writing.

7.1.1 Talk to them about it - Speaking to a person directly is best when:

- The working relationship is still reasonably positive;
- The unwanted behaviour is recent;
- There is mutual willingness to discuss the issues and work for a win-win outcome.

7.1.2 Talk to someone else about it - Speaking to someone else, this could be:

- A colleague;
- Any manager;
- Trade Union Representative;
- Alder Centre
- This is best when you want some further advice or to clarify your feelings before discussing the situation with the individual involved.

Support and advice may also be sought from their Trade Union representative, a HR Representative, or from Occupational Health. Staff are also encouraged to seek advice and guidance from Freedom to Speak up (FTSU) Guardians / Champions, to discuss their concerns. Relevant external organisations are also available for advice and support (see Appendix A, section 5) with the aim of identifying and resolving the issues without recourse to the formal procedure.

7.2 Facilitated Conversations

It is the role of the line manager or a more senior manager to facilitate resolution to apparent concerns between staff as they affect working relations and/or performance. This may be at a point before or at the informal stage and is designed to:

- Address workplace concerns raised by the manager or another member of staff with the relevant member(s) of staff
- Understand the situation from the perspective of those involved
- Exploring the impact of the concerns on the individuals involved and the service
- Explore and develop realistic solutions

The facilitating manager will meet individually with each of the members of staff involved before bringing them together and will then lead the joint meeting, if acceptable to both parties; giving time for each member of staff to explain their concerns and discuss ways of resolving the problem.

The role of the manager as facilitator is to promote both a shared resolution to the concerns of the staff, and in so doing ensure that the staff understand the standards of behaviour and performance expected of them. The manager should set out their expectations in writing, with a documented action plan following the meeting.

Please contact your HR representative for advice and guidance.

7.3 Mediation

Mediators are new to the dispute, disagreement, upset and are not involved in the work area. Mediation is a voluntary and confidential process that brings together people who are experiencing problems with a work related relationship.

They will make sure that the meetings are conducted in a fair and productive way. The aim of the mediation process is for those present to come to a resolution. Individuals coming to mediation must have the will to implement the resolutions they propose and reach agreement about future behaviour. Staff are not entitled to be accompanied by anyone supporting them during mediation (including Trade union Representation or other Managers) Mediation should be simply the two staff members concerned and the mediator to give it its greatest chance of success.

If in the employee feels the mediation has been unsuccessful, they may invoke a formal procedure if they feel it is appropriate, in this case the mediators will not be involved. Please contact HR and/or staffside for advice and guidance.

The Trust has a number of formally trained mediators for staff to access. Further information regarding mediation can be found in the accompanying Respect at Work Toolkit. Mediators will not be ordinarily be required beyond this point however mediators may be asked to provide information regarding the mediation process, but not specific details / content of the mediation meeting(s). Please contact the HR department who can provide a list of current trained mediators within the Trust. If no mediators are believed to be acceptable to either party the Trust will endeavour to identify mediators from an external source e.g. another Trust.

7.3 Grievance or Bullying and Harassment Complaint?

A grievance is an opportunity for an employee to raise a matter in work in relation to their employment that is causing them concern. A complaint is a serious issue where a member of staff may feel that they are being subjected to inappropriate and disrespectful or discriminatory behaviour that may affect their health and wellbeing. Please refer to the *Trust Grievance Policy, which is available on the Intranet.*

7.4 Formal Approaches

Where informal approaches have failed or are considered inappropriate, staff are advised to bring a formal complaint. Consideration should be given to pursuing the matter formally if an informal approach has not resolved the matter; if there has been a previous incident(s) of bullying or harassment involving the same individual(s), or the alleged perpetrator's manager considers the alleged act is serious enough to warrant formal proceedings.

If it is believed that the complaint is of an extremely serious nature and therefore may be classed as gross misconduct, a formal investigation may be required, as informal approach may not be appropriate. Please see Appendix C.

The complainant may pursue the matter formally by making a verbal or written statement in any of the following ways;

- To their own line manager.
- To the alleged accused's line manager, especially if the alleged accused is the complainant's own line manager.
- To the HR Representative for the Division / Department.

The complaint should state:

- The name(s) of the person being complained about,
- The nature of the complaint e.g treatment resulting in loss of dignity or respect, harassment, bullying etc,
- The dates, times and places where the incident(s) took place,
- The name(s) of any person(s) who witnessed any of the incident(s),
- Details of any action taken by the complainant or others to stop the alleged negative behaviours being complained about.

This may be done in liaison with a Trade Union representative or work colleague. Please see Appendix B (flow chart for this process). A formal complaint should be acknowledged within 5 working days of receipt.

The formal investigation process will be dealt with using the Trust Investigation Policy. Please refer to this Policy which can be found on the Trust intranet.

8. Review Process

The member of staff should receive the outcome letter within 7 working days, of the hearing. If they are not satisfied with the outcome of a Bullying and Harassment complaint / investigation, either party has the right to appeal the above processes. See Appendix C for further details.

9. Support

- Occupational Health (Team Prevent)
- Counselling (Alder Centre)
- HR Department
- Mediation Services
- Facilitated conversations
- Mental Health First Aiders
- Equality and Diversity Manager
- Staff Advice Liaison Services (SALS)
- Staffside

10. Monitoring

This policy will be periodically reviewed by the HR Department and the People and Wellbeing Committee.. It will incorporate monthly HR dashboard reporting contained within Board and Corporate reporting processes. Formal review of overall Policy and Procedure will be initiated by the Human Resources Business Partner - Policy Lead.

11. Further Information

Equality Analysis (hyperlink)

References

- ACAS
- Equality Act 2010

Associated Documentation

- Disciplinary Policy
- Grievance Policy
- Supporting Staff Policy
- Violence and Aggression at Work and Zero Tolerance Policy
- Managing Stress at Work Policy

- NHS Employers guidance on bullying and harassment http://www.nhsemployers.org/Aboutus/Publications/Documents/Bullying%20and%20harassment.pdf;

- Alder Hey “Raise it Change it” campaign; Trust intranet

- The Francis Review 2015 - http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-whistleblowing/sir-robert-francis-review-of-whistleblowing-processes#3;

Appendix A - Guidance

1. Definitions and Examples

1.1 Harassment

In general terms, harassment can be described as any unwanted conduct related to a protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual. Harassment is identified by the effect that it has on the recipient, not by the intention or non-intention on the part of the alleged perpetrator.

People can be subject to inappropriate behaviour on a wide variety of grounds or relating to a protected characteristic (pc) https://www.acas.org.uk/if-youre-treated-unfairly-at-work/being-harassed

Appropriate, constructive and fair criticism of an employee's performance or behaviour at work is not harassment.

1.2 Sexual Harassment

Sexual harassment happens where any form of unwanted verbal, non-verbal or physical conduct of a sexual nature occurs, with the purpose or effect of violating the dignity of a person, or of creating an intimidating, hostile, degrading, humiliating, or offensive environment. Harassment on grounds of gender reassignment is also prohibited by the Equality Act 2010.

1.3 **Values and Behaviours** – Trust Behavioural Framework

Alder Hey Children's NHS Foundation Trust has a framework of behaviours that all staff are expected to uphold. See the Trust intranet for the Trust Behavioural Framework. In summary these expected standards of behaviour are aligned to our 5 core values:

- **RESPECT** – We show that we value every individual for who they are and their contribution.
- **EXCELLENCE** – We pride ourselves on the quality of our care, going the extra mile to make Alder Hey a safe and special place for children and their families.
- **INNOVATION** – we are committed to continually improving for the benefit of our patients.
- **TOGETHER** – We work across the Alder Hey community in teams that are built on friendship, dedication, care and reassurance.
- **OPENNESS** – We are open and honest and engage everyone we meet with a smile.

Our values outline the standards of attitude and behaviour we expect of ourselves and others (for example staff, patients, relatives and members of the public) when carrying out our responsibilities as employees.

1.4 Stalking

Stalking is a particularly extreme form of harassment, which is both a civil wrong and a criminal offence. It can be defined as 'a series of acts which are intended to, or in fact do, cause harassment to another person'.

If a member of staff feels that stalking is taking place, related to another member of staff of the Trust, they should raise the matter formally in line with the notification routes within this policy.

As stalking is a criminal offence, the member of staff should also involve the police if they feel this is necessary.

1.5 Victimisation

Treating a complainant less favourably because they are suspected/have made a complaint of harassment under this policy.

1.6 Complainant

The individual who has raised an allegation of harassment or bullying against another member of Trust staff, patient, relative or other member of the public.

1.7 Person which the complaint is made against

The individual whom the complaint has been made against.

2 Legal Framework

2.1 Certain types of bullying and harassment are regarded as unfair discrimination and the victim can seek legal redress.

2.2 Harassment on the grounds of sex, race, disability, sexual orientation, age and religion and belief are all covered in law. Employers are liable for the activities of their employees where they know, or should know, about their conduct and take no action to prevent inappropriate behaviour. Harassment on the grounds of age is currently unlawful within European Community legislation.

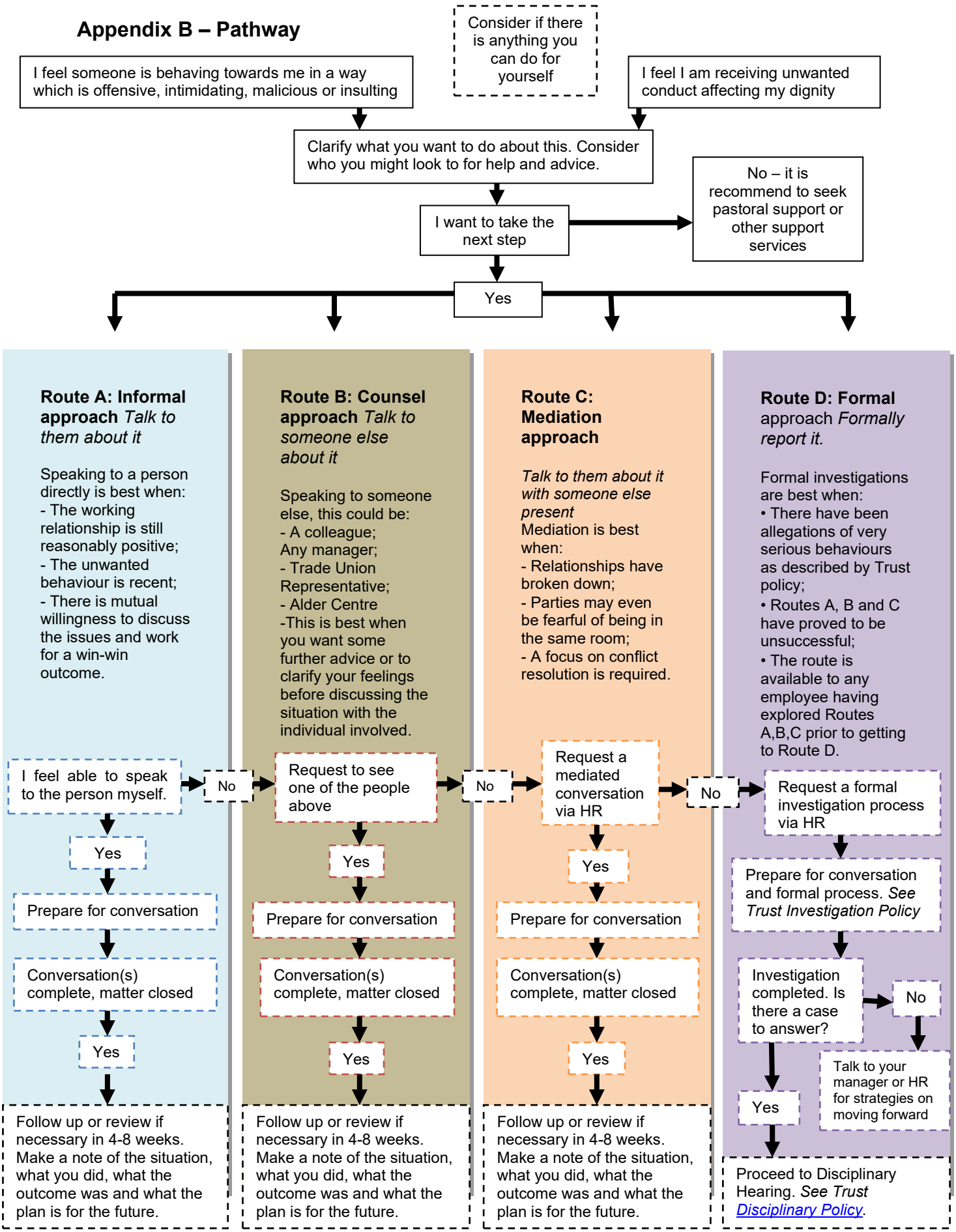
2.3 It should also be noted that employees can now complain of behaviour they find offensive even if it is not directed at them in line with the Equality Act 2010[3]

3 Useful Contacts

Trade Union/Staff Side representatives A list of Trade Union/Staff Side representatives can be found on the Trust Intranet	**Human Resources Dept** Main HR telephone number 0151 293 3500 Email address askhr@alderhey.nhs.uk
Equality and Human Rights Commission Helpline Tel: 0808 800 0082 Text phone: 0808 800 0084 Website: www.equalityadvisoryservice.com	**Department for Business Enterprise and Regulatory Reform (BERR formally DTI):** Tel: 020 7215 5000 www.direct.gov.uk

Age Positive **www.agepositive.gov.uk**	**Stonewall** Tel. 08000 502 020 www.stonewall.org.uk
ACAS Tel. 0300 123 1100 www.acas.org.uk	**Others useful external contacts** • Citizens Advice Bureau • Samaritans • National Helplines

Appendix B – Pathway



Appendix C

1. Processes

1.1 The nature of the investigative process and remit of the investigator will typically result in one of three concluding statements: -

Where sufficient evidence is identified:

- *'Consistent with the Trust's criteria for bullying and harassment and the investigative process and procedure, the complainant's case has been upheld on the basis of the evidence produced.'* If the manager considers a breach of discipline has occurred, a disciplinary hearing will be convened. Please refer to the Trust Disciplinary Policy.

Where sufficient evidence is NOT identified:

- *'Consistent with the Trust's criteria for bullying and harassment and the investigative process and procedure, there was insufficient evidence to uphold the complainant's case.' – no further action will be considered against the alleged perpetrator*

Other:

- *'Consistent with the Trust's criteria for bullying and harassment and the investigative process and procedure, there was insufficient evidence to uphold the complainant's case. However certain factors emerged as part of the investigation that may warrant remedial action by the Commissioning manager in order to avoid future misunderstanding or conflict and are outlined in the following recommendations....'*

The Commissioning Manager will provide recommendations in line with information that has come to light during the investigation. These recommendations should be monitored and reviewed by the relevant line manager with the support of the Human Resources Representative.

1.2 Whether disciplinary action is taken or not, consideration should also be given to restoring the working relationship between the parties involved - see section 3 below.

2 Working Relationships

2.1 When a formal complaint is upheld, it may be appropriate to consider counselling for the alleged as they may be unaware of, or insensitive to, the impact of their actions. Counselling, with the consent of the individual concerned may help to raise awareness of the issues and prevent further incidents.

2.2 In addition, where an incident of bullying or harassment has occurred, the impact on the working relationship between the complainant and the perpetrator should be considered. Where necessary, support should be provided to both parties to facilitate a satisfactory reconciliation. The objective of this is to restore a professional working relationship at the earliest possible opportunity in which each party respects the dignity of the other.

2.3 Where the working relationship between the parties involved is considered to be damaged, all reasonable steps to re-build the working relationship must be evaluated and taken. Measures may include setting standards of behaviour, team building, facilitation and counselling. This should be supported by appropriately trained people.

2.4 Once a decision has been made regarding any appropriate formal action and appropriate steps to re-build the relationship, it is possible that the working relationship between the parties may still be damaged. In very rare, exceptional cases the Trust may consider it necessary to transfer one of the parties to alternative work within the Trust. However, it must be acknowledged that such action may not be practical, desirable or feasible and any adverse message this may communicate to the Trust regarding the management of bullying or harassment must be considered. Before considering transferring either party, the relevant manager must seek advice from the Human Resources Representative and all reasonable alternatives evaluated, and where practicable, carried out.

3 Voluntary Transfer

3.1 Where a voluntary transfer is requested by the perpetrator or the complainant, a Human Resources Representative must always be consulted and the request fully considered.

3.2 The following factors should be considered before proceeding with a voluntary transfer:

- The likelihood of a post on the same grade being available.
- The individual having the skills and experience to undertake other posts
- The ability of the individual to develop any additional skills within an appropriate time scale.

3.3 Where it is considered that a post may be suitable, the employee will be given support from Human Resources and their manager in making an application. Whilst the Trust will be under no obligation to create a post, the employee will be provided with information on vacancies and supported in their applications for a pre-determined period which would normally be up to a maximum of three months.

3.5 It may be that no alternative post is found or that a transfer is not considered feasible from the outset. In either case it will be necessary to consider what measures are appropriate to enable the employee who requested a transfer to continue in their existing post. The appropriate measures may include team building, facilitation and counselling.

4 Review Procedure

Either party will have the right of review as follows:-

4.1 The complainant

A complainant has the right of appeal/review against any formal decision taken as a result of the investigation. This right must be stated in the outcome letter responding to the complaint within the Respect at Work Policy.

The complainant may request a review if it is felt that the process of investigation and/or decision to not uphold any element of the claim is considered by the claimant to be unsatisfactory. Right of appeal will not apply in relation to the severity of the outcome (if upheld) or management sanction applied subsequently either as part of informal / formal Disciplinary action. For example:-

- If the procedure was not followed correctly;
- If new information has materialized;
- If extenuating circumstances were not taken into account;

Any appeal must be lodged in writing by the employee no later than 10 working days from the date of the outcome letter and should be addressed to the next level manager of the commissioning manager. The written appeal must contain the specific grounds on which the appeal is based. Depending upon the circumstances or the grounds (for example if the outcome is a dismissal) the appeal should be referred to the Director of HR.

4.2 Person complaint is being made about

Staff who may be subject to Disciplinary Action following the outcome of the Bullying & Harassment investigation will have rights of appeal as defined within the Disciplinary Policy. The decision of an Appeal is final and binding. This stage constitutes the end of the process and there is no further opportunity to review. Please see the Trust Disciplinary Policy and Trust Investigation Policy.

Nothing in this document will prejudice the employee's right to refer a claim to an Employment Tribunal.

Appendix D – Glossary of Terms

Term	Description
Cyber Bullying	The use of electronic communication e.g. email, Facebook, internet or text messaging, Twitter etc to bully a person typically by sending messages of intimidating or threatening nature.
Direct Discrimination	Occurs when someone is treated less favourably than another person because of a protected characteristic.
Discrimination by association	This is direct discrimination against another because they associate with another person who possesses a protected characteristic.
Discrimination by perspective	This is direct discrimination against an individual because others think they possess a protected characteristic. It applies even if the person does not actually possess that characteristic. It applies even if the person does not actually possess that characteristic.
Indirect Discrimination	Occurs when an organisation has a rule, Policy or practice that applies to everyone but particularly disadvantages people who share a protected characteristic.
Discrimination arising from a disability	Disabled person is treated unfavourable not because they have a disability (which would be direct discrimination) but because of something that is connected with their disability; and that treatment cannot be objective justified as being a proportionate means of achieving a legitimate aim.

Alder Hey Children's NHS Foundation Trust

M2 – SAFEGUARDING ADULTS POLICY

Version:	5
Ratified by:	Clinical Quality Steering Group
Date ratified:	09/11/2021
Name of originator/author:	Julie Knowles
Approved by:	Community Policy & Procedures Sub-Group
Date approved:	03/11/2021
Name of Executive Sponsor:	Chief Nurse
Key search words:	Safeguarding, Adults, M2
Date issued:	November 2021
Review date:	November 2024

Quick Reference Guide – Safeguarding Adults Policy

This policy applies to all Trust staff and should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Alder Hey NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/ adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Alder Hey's policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

SAFEGUARDING ADULTS KEY MESSAGES

The Trust has a duty to ensure that all staff involved in the direct care of patients, understand the importance of safeguarding and promoting the welfare of adults to ensure that all patients receive appropriate and timely therapeutic and preventative interventions.

The Trust's Safeguarding Adults Policy and the Safeguarding children Policy and associated Safeguarding procedures gives detailed guidance to all staff on how to respond to a range of safeguarding issues and make appropriate and timely referrals.

All Trust staff who have contact with adults with health, care and support needs should have knowledge of the predisposing factors, signs and indicators of harm. They should be able to exercise professional skill in terms of effective information sharing and the ability to analyse this information. They should also have the knowledge and skills to collaborate with other agencies and disciplines in order to safeguard the welfare of children and adults with health and care and support needs.

The Trust also has a responsibility to ensure that adult learners and apprentices are safeguarded whilst studying at Alder Hey.

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
5	November 2021	Cath Creed	Current	
4.2	July 2019	Cath Creed	Archived	Revised and updated inline with policy review
4.1	April 2019	Cath Creed	Archived	Revised wording to include adult learners and apprentices
4	October 2018	Julie Knowles	Archived	Reviewed as recommended by CCG for annual monitoring purposes and with reference to revised statutory guidance.
3	September 2016	Julie Knowles	Archived	Revised in line with statutory guidance published April 2016 supporting The Care Act 2014
2	July 2016	Julie Knowles	Archived	Revised training groups for adult safeguarding training to reflect the Bournemouth Competency Framework
1	January 2016	Julie Knowles	Archived	

Record of changes made to Safeguarding Adults Policy – Version 5			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Intro	6	Link to Merseyside SAB and The Care Act updated	Updated online links since previous policy review
Intro	6	Reference to Intercollegiate framework document	Updated training guidance
Intro	6	Pan Merseyside Harmful Practices Strategy 2018-2020 link added	New guidance since previous policy update
Aims	8	Clinical Quality Steering Group included to replace previous Integrated Governance Committee	Updated committee information
4	11	Updated domestic abuse definition	Reflect change in law
4	12	Updated link to Modern Slavery Act 2015	Updated guidance
6	15	Updated Pan Merseyside safeguarding procedures link	Update to online links
6	16	Updated link to Trust Whistleblowing Policy	Update to online links
11	20	Sentence in regard to an adult being patient, carers or staff member	Clarity of when staff have a duty in regard to safeguarding adults processes and policy

11	21	Updated link to Incident and allegations policy	Update to online links
14	25	Reference to Intercollegiate framework document	Updated training guidance
App A	33	Links to Merseyside and NW safeguarding policy and procedure, Working Together to safeguarding Children (2018)	
App D	38	Offer of safeguarding supervision offer update to reflect safeguarding team roles and reactive and planned supervision offer	Reflect team activity

Contents

1 Introduction

1.1 Every adult has the right to live their life free from violence, fear and abuse. All adults have the right to be protected from harm and exploitation. In addition, all adults have the right to independence, which involves a degree of risk.

1.2 The Trust acknowledges that a small but significant number of adult patients each year access the services of the Trust. Many of these patients will have been patients for many years and achieve adulthood while under the care of Alder Hey Children's NHS Foundation Trust. It is highly likely that they have complex medical and nursing needs and be known to a number of specialities within the Trust and will require a comprehensive transitional care pathway to adult services.

1.3 Many of these young adults may also have profound and multiple learning disabilities and will therefore lack capacity to make decisions about their care. It is important that staff understand the framework and processes associated with caring for patients who lack capacity and that they can support patients, families and carers to achieve optimal outcomes for those young adults.

1.4 The Trust has a duty to ensure that all staff involved in the patient's direct care, understand the importance of safeguarding them to ensure that all affected patients receive appropriate and timely therapeutic and preventative interventions.

1.5 The Safeguarding Adults policy will comply with all National and Local policy guidance and should be read in conjunction with;

- Working Together to Safeguard Children (2018)
- Adult Safeguarding Roles and Competencies for healthcare staff (RCN, 2018)
- Care and Support Statutory Guidance (2018)
- Merseyside Safeguarding Adults Board Safeguarding Procedures and North West Safeguarding Adults Policy https://www.merseysidesafeguardingadultsboard.co.uk/procedures/adults-procedures/
- Building Partnerships, Staying Safe - The health sector contribution to HM Government's *Prevent* strategy: guidance for healthcare organisations (2011)
- The Care Act (England, 2014 revised 2016) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
- Pan Merseyside Harmful Practices Strategy 2018-2020 https://www.merseysidesafeguardingadultsboard.co.uk/wp-content/uploads/2018/07/Pan-Merseyside-Harmful-Practices-Strategy-1.pdf

1.6 Aims

1.7 Safeguarding Adults is, "everyone's business." Employees need to know the appropriate actions to take in order to protect and safeguard adults from abuse. This policy has been developed to describe the responsibilities of employees and organisation for the recognition and prevention of abuse and clarify the actions to take when abuse is suspected or identified.

1.8 Adult safeguarding means to work with an individual to protect their right to live in safety, free from abuse, harm and neglect. This can include both proactive and reactive interventions to support health and wellbeing with the engagement of the

individual and their wider community. The aim is to enable the individual to live free from fear and harm and have their rights and choices

1.9 The policy also recognises the risk to Alder Hey NHS Foundation Trust if employees do not demonstrate appropriate actions are taken in response to safeguarding.

2 Purpose

2.1 To give all staff guidance on how to respond to a range of safeguarding Adult issues.

2.2 Policy Statement

2.3 The Trust has a duty to safeguard and promote the welfare of adults with additional health, care and support needs, and must ensure that all staff who come into contact with such adults will do this in accordance with the policy and guidance procedures set out below. All Trust personnel must therefore;

- Follow the Safeguarding procedures
- Use the associated documentation where relevant
- Attend the mandatory safeguarding training specific to role – see Safeguarding Children and Safeguarding Adults Training Needs Analysis and strategy
- Be familiar with the Trust safeguarding web resource available to all staff via the Trust Intranet

3 Duties

3.1 The Government has placed the issue of adult protection on the political agenda. The issue has been highlighted in recent Acts of Parliament and Government guidance documents, most notably: Criminal Justice and Courts Act 2015, Public Interest Disclosure Act 1998, Safeguarding Vulnerable Groups Act 2006 and the Protection of Freedoms Bill, Sexual Offences Act 2003, The Care Act 2014, Domestic Abuse Act 2021.
Modernising Social Services: Making Decisions: Action for Justice: Living Without Fear: Caring for Young People and Vulnerable Adults; Achieving Best Evidence; No Secrets.

3.2 Trust Board

The Board has ultimate responsibility for ensuring that an effective system for managing any risks associated with safeguarding adults exists within the Trust and that all staff working in the Trust are aware of and operate within the policy. The Board will assure itself of compliance with this policy through the accountability arrangements delegated to the Clinical Quality Steering Group and via consideration of an annual report prepared by the Safeguarding Lead.

3.3 Chief Nurse

The Chief Nurse is the Trust Board member with individual responsibility for ensuring that a policy and procedure for effective safeguarding of adults exists; that it is implemented effectively; that all staff are aware of and operate within the requirements of the policy and that systems are in place for the effective monitoring of the standards contained within the policy.

3.4 Clinical Quality Steering Group

The Clinical Quality Steering Group is an established part of the governance structures of the Trust which has the responsibility to ensure that safeguarding of adults' arrangements are managed appropriately across the organisation. The Committee ensures that the policy framework is appropriate and receives assurances in relation to compliance with the requirements of this policy through receipt of reports, audit activity.

3.5 Safeguarding Strategic Governance Group

This Group will support the Executive responsible for Safeguarding in providing reports to the Board or one of its committees on all matters relating to Safeguarding within the Trust. In particular the Group will:

- Support the generation of the annual reports to the Board (or delegated committee) in relation to safeguarding both children and adults;
- Make recommendations to the Board on safeguarding issues

3.6 Local Adult Safeguarding Boards

The Local Authorities covered by Alder Hey's services have established Local Adult Safeguarding Boards which have responsibility to ensure effective multiagency arrangements are established within their geographical area. Alder Hey Children's NHS Foundation Trust Care has a duty to co-operate with these arrangements. The respective Boards have the responsibility to commission Serious Case Reviews where appropriate which the Trust is fully committed to support.

3.7 Named Nurse and Named Doctor for Safeguarding

The Named professional's for safeguarding hold responsibility to lead on all aspects of the Trust contribution to the safeguarding of adults and the promotion of their welfare within Alder Hey. The Named professionals are responsible for assuring the Board that a high-quality evidence-based safeguarding service is being provided within Alder Hey NHS Foundation Trust. They will provide professional and clinical leadership and be a source of expertise on matters relating to safeguarding adults for the Trust, local healthcare providers and other local agencies and organisations. They have the day-to-day operational responsibility for safeguarding adults.

3.8 Trust Safeguarding Team

The Safeguarding Team provide training, consultancy and advice on all matters related to adult and children's safeguarding issues and members of the Team are available as a Trust resource for practitioners, service users and their carers, Monday to Friday 09.00-17.00. Out of hours, staff should contact the bleep holder or the on-call consultant for child protection.

3.9 All staff

The duties contained within this policy apply to contracted, substantive, temporary, seconded and volunteer staff. All members of staff have a duty and a personal responsibility to share concerns of a safeguarding nature in relation to the abuse of children and adults. The Trust is operating a zero-tolerance approach in relation to the abuse of children and adults and as such doing nothing about such concerns is

not acceptable. Staff have a duty to protect adults from significant harm and abuse including knowing how to recognise abuse and to understand how to bring any concerns to the attention of professional staff or the appropriate agencies.

3.10 **Professional staff**

All professional staff have a duty to report abuse and to act on complaints of abuse (e.g. Nursing and Midwifery Council Code of Conduct; Royal College of Nursing and Health Care Professionals Council Code of Conduct, General Medical Council). It is the responsibility of all professional staff to be aware of, and be working within, the guidance laid down within the relevant multi-agency procedures for safeguarding adults established in the local authorities of Liverpool Sefton, Knowsley (or responsible local authority where individual resides) referred to within this policy.

3.11 All professional staff have a duty to work in partnership with service users and carers in order to meet their identified needs and ensure service users are protected from harm.

3.12 All staff, volunteers and representatives of agencies undertaking work on behalf or within buildings of Alder Hey NHS Foundation Trust have a duty to accept the principle that agencies work together in order to ensure health and social care is appropriately coordinated and people are protected from potential or actual abuse. Staff are expected to maintain close links with all relevant statutory and voluntary bodies in the pursuit of achieving prevention and protection of abuse of adults and children. All staff also have a duty to alert the school nurses as well as health visitors in all cases where service users are parents or carers of children.

3.13 **Line Managers**

i. Ensure that all staff members are aware of the Trust Safeguarding Policy and Procedures together with their individual role in safeguarding and promoting the welfare of all children and vulnerable adults.

ii. Ensure all staff members receive the role specific training and supervision needed to recognise and act upon safeguarding concerns and respond to the needs of children or vulnerable adults.

iii. Ensure all staff have easy access to the Trust Policy and Procedures

3.14 **Medical Staff**

i. All Trust medical staff must maintain their skills in the recognition of abuse and be familiar with the procedures to be followed if abuse and or neglect is suspected.

3.15 **Individual Staff Members**

i. All health professionals working directly with children or vulnerable adults should ensure that safeguarding and promoting welfare forms an integral part of all stages of care delivery and do this in accordance with the Trust's Safeguarding Policy and procedures.

ii. Must respond appropriately to safeguarding concerns and make appropriate and timely referrals

iii. Must respond to requests by Children's / Adult Social Care or other agencies regarding safeguarding children and vulnerable adult issues.

iv. Participate in specific types of assessment and any other role required for multi-agency working to safeguarding children and vulnerable adults.

v. Make timely, appropriate referrals to the Trust safeguarding team and relevant multi agencies.

vi. All lone workers must adhere to the **Preventing and Managing Violence and Aggression at Work and Lone Worker Policy - RM9** (see DMS) in order to reduce or eliminate any potential risk to themselves.

vii. The apprenticeship team should use Procedural Flowchart and **Safeguarding Procedures** (see DMS) if an adult learner or apprentice discloses abuse or abuse is suspected

4 Definitions

4.1 Prior to Care Act 2014 Adult Safeguarding referred to vulnerable adults, which was defined as: "Any person over the age of 18 who is, or may be in need of, care services by reason of mental or other disability, age or illness, and who is, or may be unable to take care of themselves or is unable to protect themselves against harm or exploitation" (Law Commission, 1995).

4.2 However, the Care Act 2014 redefined safeguarding duties as applying to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

4.3 The Definition of National Eligibility Threshold

4.4 The regulations say an adult's needs meet the eligibility criteria if:

(a) The adult's needs arise from or are related to a physical or mental impairment or illness;
(b) As a result of the adult's needs the adult is unable to achieve two or more of the specific outcomes detailed below; and
(c) As a consequence, there is, or is likely to be, a significant impact on the adult's well-being.

The specified outcomes are:

(a) managing and maintaining nutrition;
(b) maintaining personal hygiene;
(c) managing toilet needs;
(d) being appropriately clothed;
(e) being able to make use of the adult's home safely;

(f) maintaining a habitable home environment;
(g) developing and maintaining family or other personal relationships;
(h) accessing and engaging in work, training, education or volunteering;
(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and
(j) carrying out any caring responsibilities the adult has for a child.

4.5 **Definitions of Abuse:**

4.6 The Council of Europe defines abuse as:

"Any act, or failure to act, which results in a significant breach of a vulnerable person's human rights, civil liberties, bodily integrity, dignity or general wellbeing; whether intended or inadvertent; including sexual relationships or financial transactions to which a person has not or cannot validly consent, or which are deliberately exploitative". Safeguarding adults & children with disabilities against abuse, (**Council of Europe, 2002).**

4.7 The definition of abuse used in the guidance "No Secrets" **(DoH, 2000)** is:

"Abuse is a violation of an individual's human and civil rights by any other person or persons".

4.8 Abuse is defined in the Care Standards Act **(2000)** as:

"Single or repeated acts, or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress, including physical, emotional, verbal, financial, sexual, racial abuse, neglect and abuse through misapplication of drugs".

4.9 Key issues relating to abuse:

- Abuse may be a single incident, but is more likely to be part of a systematic pattern. The risk of being abused depends upon the situation, the environment and the perpetrators, not primarily on the behavior of the victims.
- Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it, resulting in the deterioration of a person's physical, emotional, social or behavioral development.
- Abuse may be a deliberate act or may be the result of a failure to act appropriately.
- Abuse may constitute a criminal offence.

4.10 **Categories of abuse**

4.11 The Care and Support Statutory Guidance (2016) supersedes the previous guidance and broadens the definitions

4.12 **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

4.13 **Domestic violence** – physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse, psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct. In December 2015 the offence criminalising coercive or

controlling behaviour became law, so called 'honour' based violence and Female Genital Mutilation (or cutting).

4.14 **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

4.15 **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

4.16 **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. Revisions in statutory guidance to support The Care Act 2016 incorporates the impact of the internet, postal and doorstep scams

4.17 **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
https://www.gov.uk/government/collections/modern-slavery-bill

4.18 **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion. Read Discrimination: your rights for further information.

4.19 **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

4.20 **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

4.21 **Self-neglect** – this covers a wide range of behaviour e.g. neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

4.22 It is important to remember that these categories of abuse are not mutually exclusive, and many situations contain a combination of different kinds of abuse. The Equalities Act 2010 defines certain protected characteristics; age, disability, gender

reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief; sex; sexual orientation.

4.23 In dealing with potential adult abuse, practitioners should be aware that some individuals, for example pregnant women, transgender individuals and gay men and women, may on occasions be subject to targeted abuse.

4.24 **Domestic Abuse** - Furthermore, domestic abuse can feature or encompass many of these dimensions. Further information in relation to the awareness, reduction and management of domestic abuse can be found within The Trust **Domestic Violence and Abuse Policy – M70** (see DMS).

4.25 Incidents of domestic abuse should be reported on the day they are observed. Incidents of this nature may need to be escalated to the Family Crime Investigation Unit (FCIU)/Vulnerable Persons Unit (VPU) by the practitioner directly or through the Trust's Safeguarding Team. The requirements and thresholds in relation to referrals to the Unit and any requirements to undertake a Multi-Agency Risk Assessment Conference (MARAC) are detailed within Trust Domestic Violence and Abuse Policy referred to above.

4.26 **Definition of Significant Harm**

4.27 In determining how serious the degree of abuse must be to justify intervention, it is helpful to consider whether the person has suffered, or is likely to suffer, "significant harm".

4.28 The Law Commission defines significant harm as:

"Harm should be taken to include not only ill-treatment (including sexual abuse and forms of ill-treatment that are not physical) but also the impairment of physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development". (Who Decides, Law Commission - 1997).

It may be difficult at the point of referral to ascertain the seriousness or extent of the abuse. In order to make an assessment of seriousness, it is useful to consider and collate:

- Vulnerability of the individual.
- Nature and extent of the abuse.
- Length of time that it has been occurring.
- Impact on the individual.
- Risk of repeated acts involving this or other vulnerable people.

4.29 **Definition of hate crime or incident**

4.30 Hate crimes are any crimes that are targeted at a person because of hostility or prejudice towards that person's:

- disability
- race or ethnicity
- religion or belief
- sexual orientation
- transgender identity

4.31 This can be committed against a person or property.

4.32 A victim does not have to be a member of the group at which the hostility is targeted. In fact, anyone could be a victim of a hate crime.

4.33 Hate Incidents can feel like crimes to those who suffer them and often escalate to crimes or tension in a community.

4.34 **Definition of female genital mutilation (or cutting).**

4.35 Female Genital Mutilation (FGM) (or cutting) is illegal in the UK. It is also illegal to take a British national or permanent resident abroad for the purpose of FGM

4.36 The term female genital mutilation applies to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth also causing dangers to the child. If this practice is disclosed to any Trust staff, then advice and guidance must be sort from the Trust Safeguarding Team immediately.

5 Principles (Beliefs)

5.1 This policy is based on the following key principles:

5.2 Everyone has the right to live their life free from violence, fear and abuse.

5.3 All adults have the right to be protected from harm and exploitation.

Empowerment - People being supported and encouraged to make their own decisions and informed consent.
Prevention - It is better to take action before harm occurs.
Proportionality -The least intrusive response appropriate to the risk presented.
Protection - Support and representation for those in greatest need.
Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability - Accountability and transparency in delivering safeguarding.

5.4 Effective inter-agency working is crucial for effective safeguarding and protection of adults from abuse. Although Social Services are the lead agency in working with those vulnerable to abuse, protecting adults from harm is not the sole responsibility of any one agency.

5.5 All agencies and professionals are required to:

- Be alert to potential indicators of abuse and neglect.
- Alert other agencies to adults who they feel they are at risk.
- Share and assist in analysing information to enable a comprehensive assessment to occur.
- Contribute to whatever actions are needed to safeguard any individual at risk.

5.6 To act in a way which supports the rights of an individual to lead an independent life based on self-determination and personal choice.

5.7 To recognise that the right to self-determination can involve risk, and that such risks are recognised and understood by all stakeholders and that this risk is reduced to a minimum as far as possible.

5.8 To recognise at times people are unable to take their own decisions and protect themselves, their assets and their physical integrity.

5.9 To where possible to support individuals to regain the ability to make their own decisions. But when they can't to recognise their previous wishes in line with best practices relating to Mental Capacity Act and Mental Health Act.

5.10 To ensure that lessons from scrutiny reports or Serious Case Reviews / Safeguarding Adult Reviews / Domestic Homicide Reviews are adopted into practice.

6 Policy (What)

- This policy should be used in conjunction with the **Merseyside Safeguarding Adults Board Safeguarding Adults Policy and Procedures.** These documents mirror The Care Act (DoH 2014) and The Care and Support Statutory Guidance (2018)

6.1 This policy directs staff towards these multi-agency arrangements to ensure consistent and coherent responses to safeguarding adult issues.

6.2 The procedural framework within this policy indicates the fundamental steps that should be taken when any concerns are generated. In the first instance, staff should consult their Line Manager where appropriate. The Trust Safeguarding Team is also available to provide advice and support in relation to any adult safeguarding issues or concerns, and will use professional judgement in relation to escalation of cases. However, every Local Authority - due to their specific statutory responsibilities - has their own multiagency procedures which should be consulted to ascertain the necessary actions to be taken in each case. Liverpool, Sefton, Knowsley and Wirral local authority safeguarding adult procedures can be accessed via https://www.merseysidesafeguardingadultsboard.co.uk/procedures/adults-procedures/

6.3 In all cases of concern staff should inform their line manager as soon as possible.

6.4 If the concern relates to a member of staff, the manager must inform a senior manager or the Assistant Director of Safeguarding or their deputy who will inform the appropriate senior HR Manager.

6.5 If an individual is felt to be at risk or it is felt a crime has been committed, alerting staff have a duty to ensure any alleged victim(s) are comfortable and safe. In these circumstances the police should be contacted immediately, and medical attention sought if appropriate.

6.6 The Care Quality Commission (CQC), as the independent regulator of health and social care in England, has statutory responsibilities to ensure incidents of abuse are investigated properly under their regulatory remit. As a registered provider of

regulated services, the Trust must make the appropriate notification of any allegation of abuse through the StEIS reporting system and also promptly advise the relevant local safeguarding authorities about abuse and allegations of abuse as described in the CQC guidance about compliance with the regulatory framework. From the perspective of the Local Authority, all other agencies and organisations are considered to be referring agencies.

When Trust managers have been notified of an incident of abuse they must then engage fully in the process of networking with other agencies established by the Local Authority to help determine whether an inter-agency investigation is required.

6.7 The multi-agency procedures provide full details of how managers should make a referral.

6.8 Consultation with the Police should be made at the earliest opportunity to ensure any contemporary evidence can be collated as soon as possible.

6.9 Under the Police and Criminal Evidence Act (PACE) (1984), where an interview involves an abused person, witness or suspect, there is an obligation to provide an appropriate adult for any vulnerable or mentally disordered adult. The role of 'appropriate adult' is a specific responsibility and dedicated function and implies legal obligations which cannot be attributed to someone after any such interview. Trust staff will not therefore undertake this role unless they have received appropriate training to offer this support and provided it is described as being within their specific job role.

6.10 This policy should be read in conjunction with Alder Hey's NHS Foundation Trust's Freedom to speak up: **Raising Concerns (Whistleblowing) Policy for the NHS** (Policy E29 on DMS)

6.11 This policy complements existing guidelines such as the NMC - The Code for Nurses and Midwives (2015) and GMC Guidance on Contractual Arrangements in Health Care, and registered staff with the HCPC. Staff have a duty under these arrangements to make known areas of concern or unsafe practice in relation to patient care.

6.12 This policy takes account of the Public Interest Disclosure Act 1998, which provides legal protection for workers who raise an issue or make what is known as a protected disclosure which, in the reasonable belief of the worker, refers to one or more of the following:

- That a criminal offence has been committed, is being committed or is likely to be committed;
- That a person has failed, is failing or is likely to fail to comply with any legal obligation to which he/she is subject;
- That a miscarriage of justice has occurred, is occurring or is likely to occur;
- That the health and safety of an individual has, may have been or is likely to be endangered; and/or
- That the environment has been, is being or is likely to be damaged.

6.13 The Trust Board recognises and encourages the contribution that issues raised by staff under this policy can have in improving services and will ensure that concerns raised are handled honestly, promptly and effectively.

6.14 In addition, cases where potential fraud or financial malpractice is indicated then appropriate reference should be made to the Trust's Financial Standing Instructions and counter fraud requirements.

6.15 Staff involved in safeguarding adults work can access support from the Trust staff counselling service and the Trust Safeguarding Team.

6.16 Regular safeguarding audits will be undertaken to assure compliance with the Policy.

6.17 **Recording and Reporting Arrangements**

6.18 Staff (or volunteers and representatives of other organisations working on behalf of or for Alder Hey NHS Foundation Trust) within the Trust must work in partnership with service users, carers, Social Services and other agencies to safeguard adults. Multi-agency procedures have been developed in conjunction with the four primary host local Authority areas that exist in the geographic area related to the work of the Trust. (i.e. St Helens, Knowsley, Sefton & Liverpool).

6.19 From April 2018 the Merseyside Safeguarding Adult Board was created that oversee the Safeguarding Adults process to ensure a consistent approach is adopted by all professionals whether from a social care or health background. The board represents Knowsley, Liverpool, Sefton and Wirral councils. These procedures can be accessed directly by following the web links of this policy or from the Safeguarding Team web page on the Trust's website by following the web links within this policy.

6.20 Trust staff **who do not** have investigatory responsibility or training should be aware that it is not their responsibility to investigate mistreatment or abuse, but to gather information and work closely with any 'strategy group' constituted to oversee any investigation authorised through the multi-agency procedures.

6.21 Trust staff who have identified possible "mistreatment or abuse," should record information on the Trust systems i.e. Meditech and the Incident Reporting System They should also ensure that risk assessments are updated or, if appropriate alert the staff responsible for care coordination and risk assessment that documents need to be updated. Staff should also ensure that alerts on electronic systems are updated and where appropriate share information with the Police

6.22 **Contacting the Trust Safeguarding Team**

6.23 If staff have adult safeguarding concerns they must follow **Merseyside Safeguarding Adults Board policy and procedures.** The Trust's Safeguarding Team are available to provide advice, consultancy and support in relation to expected practice and contacts with the Local Authority Safeguarding Officers. The Safeguarding Team can be contacted via the Rainbow Centre during office hours. Out. of hours staff should contact the Bleep Holder or on call Rainbow Consultant

7 Mental Capacity Act (2005)

7.1 The Mental Capacity Act (MCA) has been developed to bring together existing legal requirements and provide consistency in decision making about the care and treatment of people who lack capacity to make a decision. Much of the Act builds on existing common law, but also encompasses important changes, including new criminal offences, IMCAs, a new Court of Protection and The Office of the Public Guardian.

7.2 Health care professionals working within the framework of the Mental Capacity Act must at all times and without exception apply the 5 statutory key principles of the Act:

7.3 **Presumption of Capacity Principle***;* – Any person 18 years or older will always be presumed to have the mental capacity to make an informed decision unless and until proven otherwise.

7.4 **Practicable Steps Principle** – A person cannot be said to lack the capacity to make a given informed decision unless and until all practicable steps have been taken to help her/him achieve this.

7.5 **Unwise Decisions Principle** – A person cannot be said to lack the capacity to make a given informed decision solely on the grounds that the decision in question is seen to be unwise or eccentric.

7.6 **Best Interests Principle** – Once it is confirmed that a person lacks the mental capacity to make a given informed decision then… any decision made on her/his behalf must be one that meets her/his best interests.

7.7 **Least Restrictive Principle** - Once it is confirmed that a person lacks the mental capacity to make a given informed decision then… any decision made on her/his behalf must be considered to be the least restrictive option likely to achieve the required outcome.

7.8 Pay ‘due regard’ to both the Mental Capacity Act Code of Practice and the Deprivation of Liberty Safeguards Code of Practice.

7.9 Comply with M69 – Mental Capacity Act and **Deprivation of Liberty Safeguards (DoLS) Policy** (see DMS)

7.10 **Independent Mental Capacity Advocates (IMCAS)**

7.11 IMCAS provide advocacy to people aged 16+ who lack capacity to make a particular decision. Additionally, Local Authorities may request that an IMCA is involved with a decision related to Adult Protection Proceedings or a Care/Accommodation Review.

7.12 When related to an Adult Protection Review or conference, an IMCA request must be considered irrespective of whether the client has family or remunerated carers.

8 The Deprivation of Liberty Safeguards (DOLS)

8.1 The Deprivation of Liberty Safeguards **apply to persons over the age of 18 who lack capacity.**

8.2 Depriving a person of their freedom may breach a person's human right to liberty (Article 5(1) European Convention of Human Rights. The safeguards protect people who lack the ability to make certain decisions for themselves and ensure their freedom is not inappropriately restricted.

8.3 There is no single definition of a deprivation of liberty. The starting point must be the specific situation of the individual concerned, with consideration of type, duration, and effect of restrictions and the manner of implementation of measures in question.

8.4 Whilst every effort should be made to avoid depriving a person of their liberty, in certain circumstances it can be necessary to enable provision of effective care or treatment. The DoLS authorisation provides the legal framework and protection when a deprivation of liberty is considered to be unavoidable, by allowing hospitals to accommodate a person in their best interest as defined by the MCA. Care must always be taken to ensure that if deprivation of liberty cannot be avoided, it should not be for longer than is necessary.

8.5 If a person lacks the capacity to consent to particular treatment or care that is recognised as being in their best interests to protect them from harm, it may be necessary to initiate deprivation of liberty safeguards (a higher threshold than proportionate restraint). This should not replace the process described when making a decision in someone's best interest).

8.6 The Deprivation of Liberty Safeguards (DoLS) ***only apply to people lacking capacity.*** A recent ruling '**Birmingham City Council & D' in January 2016** indicates that DoLS will be considered for those 16 and over, who are, or may become deprived of their liberty in a hospital or care home, when detention under the Mental Health Act 1983 is inappropriate. The Honourable Mr Justice Keehan said 'I am not persuaded that a parent can consent to the confinement of a child who has attained the age of 16. Such a consent falls outside the zone or scope of parental responsibility'. In such cases a referral to the Court of Protection for authorised and inevitably, annual review, at least until the young person becomes 18.

8.7 In March 2014 the Supreme Court set out the 'Acid Test'.

> ***The Acid Test***
> ***Is the person subject to continuous supervision <u>and</u> control?*** *(The oversight must be continuous, must amount to supervision and have a clear element of control)*
> ***AND***
> ***Is the person free to leave?****(The person may be asking to go or showing by their actions that they want to leave but the issue is about how staff would react if the person did try to leave or if relatives / friends asked to remove them)*

8.8 The Supreme Court held that factors which are **NOT** relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement.

8.9 **Process to be Used for Patients Being, or Likely to be Deprived of Their Liberty**

Comply with M69 – Mental Capacity Act and **Deprivation of Liberty Safeguards (DOLS) Policy** (see DMS).

9 PREVENT

9.1 Prevent is the Government counter terrorism strategy which aims to reduce the risks the UK faces from terrorism. This strategy aims to stop people becoming involved in or supporting terrorist activity.

For further information please access the Trust Prevent Policy - RM19 (see DMS)

10 Whistleblowing and Organisational Abuse

10.1 All staff with Alder Hey Children's NHS Foundation Trust will adhere to the NHS Constitution and its principles and values.

10.2 All staff will act consistently with the Statutory Duty of Candour contained within regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular, they must be open and honest during their employment and if they see something wrong such as a safety incident, they must raise a concern in order to ensure that the appropriate action is taken

10.3 Alder Hey Children's NHS Foundation Trust is committed to running the Trust with honesty and integrity, with the goal being provision of perfect care.

10.4 All members of staff have a duty and a personal responsibility to share concerns of a safeguarding nature in relation to the abuse of children and vulnerable adults. The Trust operates a zero tolerance approach in relation to the abuse of children and adults and as such doing nothing about such concerns is not acceptable. For more information, please consult Trust **Whistleblowing Policy - E29** (see DMS).

11 Safeguarding Adult Procedure (How)

11.1 Please see Appendix B for procedural governance flow chart for the reporting arrangements of suspected or actual abuse

11.2 **Procedure**

11.3 Suspected abuse or mistreatment of an adult may come to the notice of staff in several ways:

- Abuse or mistreatment is disclosed by the victim or a third party
- Circumstances or evidence comes to light which suggests abuse or mistreatment is taking place
- Abuse or mistreatment is directly observed
- The adult may be a patient, a parent or carer or a member of staff/colleague

11.4 Where this occurs the procedural steps indicated in the flow chart contained must be followed. In particular, alerters and referrers must act on any concerns of abuse of an adult to ensure the situation is assessed and investigated.

11.5 When abuse is disclosed, stay calm, be sympathetic, and listen carefully without interrupting. Staff should encourage the individual to say what has happened but staff need to be mindful that they do not ask any leading questions.

11.6 All cases of abuse or suspected abuse or mistreatment must be reported or discussed on the day the information comes to light. Staff should consult their line manager, and can seek advice and guidance from the Trust Safeguarding team if they are unclear as to the expected steps to take.

11.7 Staff should inform the adult about any action that they intend to take and also discuss that information provided will be handled on a confidential basis but that staff have a duty to report safeguarding concerns to their manager and if necessary other professionals and agencies for example Social Care and the Police.

11.8 Staff need to be aware that medical and forensic evidence may be required by the police in cases of physical or sexual abuse.

11.9 Staff will need to produce a written record of any allegation of abuse or concern as soon as possible. This should be clear, factual and relevant containing what information is required to describe what they have been told or witnessed including any observed or reported injuries.

11.10 Where indicated also staff should complete an Incident Form in line with the Trust's **Incident Reporting and Management Policy** – RM2 (see DMS).

11.11 Staff must ensure all cases of abuse or suspected abuse are appropriately brought to the attention of the relevant Local Authority Safeguarding adult teams by phone in first instance (with the exception of Sefton Local Authority), completion of specific local authority referral forms should then be completed and emailed to relevant team.

11.12 Staff must ensure all actions, phone calls and discussions pertaining to the case are fully documented within patient records and shared with Named Nurse for Safeguarding Adults.

11.13 Ensure that if a person is felt to be at significant risk of physical harm stemming from an abusive relationship, or if a crime has apparently been committed, the police and emergency services must be alerted immediately.

11.14 Bear in mind that carers and other family members may on occasions be regarded as being vulnerable as a result of their relationship with a service user or other family member. Where practitioners are concerned that carers and family members may be subject to abuse they have responsibility to act on their concerns.

11.15 Familiarise themselves with the practice guidance in relation to this policy developed by the Assistant Director of Safeguarding which is available through training and via the Trust intranet Safeguarding webpage.

12 Disclosure of Information

12.1 Confidentiality and Information-Sharing

12.2 *"Safeguarding Adults"*: Association of Directors of Social Services, (2005) states:

"Raising concerns about abuse or neglect nearly always involves sharing information about an individual that is both personal and sensitive. Such information about an adult with mental capacity should be shared only with their informed consent, unless there is an overriding duty such as a danger to life and limb, or risk to others. These exceptions are described in the Data Protection Act **(1998)**; "Caldicott Guidance" **(DoH 1997),** and case law in relation to human rights legislation. However, any information about an adult who may be at risk of abuse or neglect must be shared only within the framework of an appropriate information-sharing protocol".

12.3 **Making Decisions About Confidentiality and Information-Sharing**

12.4 Staff are required to adhere to the NHS Constitution and the Statutory Duty of Candour.

12.5 Staff must act consistently with the Statutory Duty of Candour contained within regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular, you must be open and honest during your employment and if you see something wrong such as a safety or safeguarding incident, you must raise it in order to ensure that the Trust can deal with it appropriately.

12.6 In making decisions with regard to confidentiality, staff should always:

- Take advice from their Line Manager.
- Ensure that they are working within agreed information-sharing protocols.
- Ensure that their decisions are in line with current legislation (e.g. Data Protection Act 1998) and Caldicott Guidance.

12.7 Consider seeking advice on complex information-sharing issues from the Caldicott Guardian.

12.8 **Disclosure Without Consent**

12.9 Consent should always be sought to share personal information. Individuals have the right to refuse or withhold consent for Alder Hey practitioners to share information in relation to suspected abuse. Wherever possible the views and wishes of the adult in safeguarding will be respected. However, if it is thought that they are in a situation that results in their abuse, or if they are abusing another person(s) the duty of care overrides the individual's refusal and the need to protect the individual or wider public outweighs their rights to confidentiality. Why a disclosure in these circumstances has been made should be explained to the adult concerned unless this act by itself increases the risk of harm.

12.10 Any decisions made in this regard must be fully recorded but decisions made to share information without consent must not interfere with that individual's human rights. In addition, circumstances in which consent to share information may not be sought, or may be deferred, include those in which a person does not have capacity and a decision is made to share the information in that person's best interests.

12.11 There are a number of other circumstances in which disclosure can take place with or without the consent of the service user.

12.12 These include:

- Where an individual presents a serious risk of harm to an adult.
- When there is no other practical, less intrusive means of protecting the adult, and failure to disclose would put them in danger.

N.B. Staff responsible for referring an allegation of abuse are accountable for their decision and should use their professional judgment when deciding whether an incident should be referred to Adult Social Care. If in doubt practitioners should **SEEK FURTHER ADVICE** but this should not result in a delay in making a referral if significant concerns exist.

12.13 In all cases where the suspected abuse involves a member of staff then a referral should be made.

12.14 **Basic Principles of Confidentiality**

12.15 All staff should be aware of their responsibility to understand and respect confidentiality and comply with the law.

12.16 The basic principle is that a person's consent should always be sought (apart from in exceptional circumstances), prior to information about them being discussed or disclosed to another party.

12.17 This consent should always be recorded together with the purpose for which staff intend to use or transfer personally identifiable information.

12.18 Information given for one purpose should not be disclosed to a third party or used for different purposes without the person's consent.

12.19 Access to personally identifiable information should be on a strict need to know basis and it is the responsibility of staff to relay information to other agencies on this basis.

12.20 Clear documentation and record-keeping must support these communications.

12.21 None adherence to legal requirements of protecting personal information of service users and patients must be considered as a Safeguarding matter.

12.22 **Incapacity to Give Consent to Share Information**

Where appropriate, if an individual is not considered to have the capacity to give consent, those providing a service should take into account the views of the person's carer or nominated representative/advocate prior to making a decision as to whether information can be shared in accordance with the best interests of the individual.

12.23 **Sharing Information with Carers**

12.24 There is no legal duty to share information with carers, but carers should wherever possible be listened to and supported. This includes parents of young adults receiving treatment and care

12.25 Staff should always seek the service user's consent to share information with his/her carer, if they are able to give it.

12.26 Where appropriate, information should only be shared with carers on a need to know basis with service users' consent.

12.27 When a young adult identifies themselves as a carer, consideration should be given to the appropriateness of this arrangement taking into consideration the presentation of the young adult and the person they are providing care to.

13 Professional Abuse

It is essential that any allegation of abuse made against a professional who works at Alder Hey Children's NHS Foundation Trust is dealt with fairly, quickly, and consistently, in a way that provides effective protection for the adult patient and at the same time supports the person who is the subject of the allegation.

If staff suspect or witness abuse perpetrated by a member of staff they must follow the detailed guidance in Section 17 of the Trust Safeguarding Procedures (see DMS).

13.1 Abuse occurs when a professional takes advantage of their client or patient's trust, exploits their vulnerability, does not act in their best interest and fails to keep professional boundaries. Professional trust is vital due to the degree of intimacy involved in providing a therapeutic relationship and the inherent power difference between a professional and the person seeking help. Such relationships are open to exploitation so it is imperative that the Allegations Against Professionals procedure is triggered and any episodes or alleged incidents of professional abuse are reported immediately to the Assistant Director of Human Resources and the Assistant Director of Safeguarding, (or in the post holder's absence their agreed deputy) as soon as this situation becomes known. The police will always be the lead agency in dealing with any criminal allegations against Trust staff.

13.2 In the event that a professional is considered to be perpetrating abuse then consideration needs to be given to making a referral to the Disclosure and Barring Service (DBS) and their professional governing body if applicable.

13.3 The DBS is a public body and part of The Home Office and became fully operational on 01/12/12.

13.4 The DBS was established under the Protection of Freedoms Act 2012 and merges the functions previously carried out by the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). Further advice and guidance on this issue can be sought from the Assistant Director of Human Resources who will consider and will act on any potential referral to the DBS on behalf of the Trust. The Executive Directors accountable for professionally registered staff, (i.e. Medical, Nursing, AMHP's and Social Workers) will ultimately determine whether any referrals to professional bodies will be made by the Trust.

13.5 It is recognised that allegations of this type can be particularly stressful for the staff directly affected by the allegation. In the event that professional abuse is suspected and an investigation is commissioned, the Assistant Director of Human Resources will maintain contact with the investigating body with a view to supporting a timely but thorough review.

13.6 Agreed protocols with the Local Authorities exist to ensure that no undue delay in completing any investigation occurs.

13.7 **Use of Restraints**

13.7.1 Alder Hey NHS Foundation Trust is committed to a process by which the use of physical intervention to support a person who may be challenging is minimised and ultimately eliminated. Where physical intervention is used there is clear policy guidance as set out within **MH2 – Safe and Therapeutic Responses to Disturbed Behaviour Policy** (see DMS) for the recognition, prevention and therapeutic management of aggression and violence.

13.7.2 Where a member of staff is involved in, or witnesses, a physical intervention where the legal and ethical parameters of policy MH2 are exceeded in terms of the nature of interventions used or their duration, then staff should act in accordance with the Trust safeguarding procedure.

14 Training

14.1 All Trust staff who have contact with children and vulnerable adults should have knowledge of the predisposing factors, signs and indicators of abuse. They should be able to exercise professional skill in terms of effective information sharing and the ability to analyse this information. They should also have the knowledge and skills to collaborate with other agencies and disciplines in order to safeguard the welfare of vulnerable adults.

14.2 Staff must be trained according to their role and responsibility and the degree of contact they have with adult patients as defined in the Training Needs Analysis (See **Mandatory Training Policy** (on DMS) for Trust agreed training strategy). Staff should also see Intercollegiate Document Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018)

15 Arrangements for Managing the Risks Associated with Caring for Adult Patients in a Children's Hospital.

15.1 A Safeguarding Adult Assessment must be carried out on any adult patient being admitted to the Trust (Appendix 2). If a member of staff has a safeguarding concern they must follow the guidelines included within the Safeguarding Procedures.

15.2 The Trust is committed to supporting patients, parents and their carers; Guidelines explaining the management process of any person thought to pose a risk to children is contained within the associated Safeguarding Procedures.

16 Monitoring

16.1 An Annual Safeguarding Report will be presented to the Trust's Clinical Quality Steering Committee, which will include:

- Local arrangements for managing safeguarding of children and adults within the Trust
- Training compliance
- Results of safeguarding audits
- Process for supporting staff involved in safeguarding issues

17 Further Information

References

- Association of Directors of Social Services (2005*)*
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- Supreme Court Ruling (2014) P v Cheshire West and Chester P and Q v Surrey County Council
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  http://services.parliament.uk/bills/2014-15/seriouscrime.html

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- **Home Office (1999)** *"Youth and Criminal Evidence Act"*
  http://www.legislation.gov.uk/ukpga/1999/23/contents

- **Home Office (1984)** "*Police and Criminal Evidence Act (PACE)"*
  http://www.legislation.gov.uk/ukpga/1984/60/contents

- Mental Capacity Act (2005)
  http://www.legislation.gov.uk/ukpga/2005/9/contents

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  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicy and Guidance/DH 4008486

- **Department of Health, (1997).**The Caldicott Committee: "Report on the Review of Patient-Identifiable Information." http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4068404.pdf

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- **Health Professionals Council, (2003) "**Standards of conduct performance & ethics." http://www.hpc-

- **Nursing and Midwifery Council, (2015)** " The Code for nurses and midwives

- **Lord Chancellor's Department, (1997) "**Who decides? Making decisions on behalf of mentally incapacitated adults." London: HMSO.

- **Law Commission, (1995)** "*Mental incapacity."* London: HMSO

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HM Government, (2018) "*Working together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children."* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf*

DoH (October 2018) "Care and Support Statutory, Guidance Issued under the Care Act 2014," https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

https://www.cqc.org.uk/files/safeguarding-adults-roles-responsibilities-health-care-services

Appendix A - Glossary

Alerters
Alerting occurs when a member of staff is informed, or has concerns, that abuse or neglect has occurred, or is suspected. The member of staff becomes the 'Alerter'. Alerters could therefore be any member of staff such as: care assistants, support workers, community nurses. Alerters have a duty to share the information with their line manager (or with the Director of Social Care & Safeguarding if the concern is about their manager, or they feel the concern has not been addressed). An Alerter should not discuss their concerns with anyone else but having a 'duty to share information' means that the alerter is not at liberty to keep concerns to themselves and staff should never promise to keep secrets.

Care Quality Commission (CQC)
The CQC are the independent regulator of health and social care in England. The CQC regulate care provided by the NHS, local authorities, private companies and voluntary organisations. The Commission's aim is to make sure better care is provided for everyone - in hospitals, care homes and people's own homes. The Commission also seek to protect the interests of people whose rights are restricted under the Mental Health Act.

STEIS
STEIS is the Trust's supplier of patient safety systems for reporting incidents and managing adverse incidents.

Directions from the Secretary of State
NHS Directions are instructions issued by the Secretary of State who has powers under NHS primary legislation to give directions to health authorities, special health authorities and NHS trusts. These are legally binding and must be complied with by the recipient.

The Disclosure and Barring service (DBS)
The Criminal Records Bureau (CRB) has merged with the Independent Safeguarding Authority (ISA) to become the Disclosure and Barring Service (DBS). From 1st December 2012 (DBS) role is to help prevent unsuitable people from working with children and vulnerable adults. The (DBS) assess those individuals working or wishing to work in regulated activity that are referred to it on the grounds that they pose a possible risk of harm to vulnerable groups. The DBS has four key areas of activity:

1) **Processing Disclosures** - The checking service currently offers two levels of DBS check; standard and enhanced.
2) **Accepting Referrals** -Referrals are made to the DBS when an employer or an organisation, for example, a regulatory body, has concerns that a person has caused harm or poses a future risk of harm to vulnerable groups including children. In these circumstances the employer legally must or regulatory body may, make a referral to the DBS.
3) **Barring unsuitable people** - A new test for regulated activity has been introduced which means the DBS can only bar a person from working within regulated activity with children or adults if we believe the person is or has been, or might in the future be, engaged in regulated activity. The only exception to this is where a person is cautioned or convicted for a relevant (automatic barring) offence and is not eligible to submit representations against their inclusion in a barred list.

4) **Making barring decisions -** The DBS makes its decisions using barring decision-making processes specifically developed for this use and approved by the DBS Board. The DBS Board is ultimately responsible for all the decisions made by the DBS.

Independent mental capacity advocates (IMCAS)
The role of the Independent Mental Capacity Advocate (IMCA) service is to help particularly people who lack the capacity to make important decisions about the serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions.
IMCAs work with, and support, people who lack capacity, and represent their views to those who are working out their best interests. Chapter 10 of the Mental Capacity Act 2005 Code of Practice provides guidance for both IMCAs and for everyone who may need to instruct an IMCA.

LADO
The role of the LADO (Local Authority Designated Officer) is set out in the HM Government guidance: *"Working Together to Safeguard Children" 2018* which outlines the procedures for managing allegations against people who work with children, for example, those in a position of Trust.
The LADO role applies to paid, unpaid, volunteers, casual, agency or anyone self-employed and includes concerns, allegations or offences emanating from outside of work. The LADO is involved from the initial phase of any allegation through to the conclusion of the case.
They will provide advice and guidance and help determine that the allegation sits within the scope of the procedures. The LADO helps co-ordinate information sharing with the right people. They will also monitor and track any investigation with the expectation that it is resolved as quickly as possible.

Multi-Agency Risk Assessment Conference (MARAC)
MARAC is a forum where multiple agencies get together to provide a co-ordinated response for those at the highest risk of domestic abuse The MARAC model of intervention involves undertaking a risk assessment in all reported cases of domestic abuse to identify those at highest risk so that a multi-agency approach may be taken. Evidence suggests that this reduces recidivism even among those most at risk. This is an intervention that combines risk assessment and a multi-agency approach to help very high risk victims of domestic abuse.

Multi-agency Safeguarding Conference
A safeguarding case conference is a multi-agency meeting, usually planned as an outcome from a safeguarding strategy meeting. The purpose of a case conference is to agree on a course of action and to ensure the agreed plan is monitored and reviewed. Unlike the strategy meeting, the adult must be invited and enabled to attend if they so wish. The outcome of a case conference is likely to be:

- Further investigation by a named agency or agencies
- Implementation of the action plan
- Agreement about monitoring arrangements
- Agreement about each agency's responsibilities
- No further action and case closed to Safeguarding Adults

Referrers
Referring is the responsibility of the nominated person who receives information from the Alerter, (usually senior or line manager). This member of staff becomes the

'Referrer'. For example, referrers might be; Ward or Clinical staff. It is important to note that "Referrers" are not a separate type of staff – referring in this context is simply an aspect of the 'manager's' overall responsibilities.

Safeguarding Adult Strategy Meeting
Where an allegation or disclosure of abuse has been made, a Safeguarding Strategy Meeting may be called by the relevant Local Authority Officer. This decision will be based on information/evidence available.

The outcome of such a Strategy Meeting will be either:

- To call a multi-agency adult protection Case Conference
- Agree which agency is to undertake any required investigation.
- That no further action is required under these procedures.

Everyone: Staff, volunteers, service users all have a responsibility to be observant about abuse. The responsibility for reporting abuse, is "every body's business" there should be "no secrets." For staff there is often a legal and professional requirement to report.

Safeguarding Adult Boards: Safeguarding Boards are now on a statutory footing. With the introduction of Care Act 2014, each local authority is required to setup a Safeguarding Adult Board. The Safeguarding Adult Boards are responsible for ensuring in that local authority area, enquires are made if it is believed an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

The Boards are also responsible for, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them.

Lead co-ordinating agency; LOCAL authorities: have the lead role in co-ordinating the multi-agency approach to safeguard adults at risk. This includes the co-ordination of the application of this policy and procedures, co-ordination of activity between organisations, review of practice, facilitation of joint training, dissemination of information and monitoring and review of progress within the local authority area.

In addition to this strategic co-ordinating role, the local authority adult social care department, joint health and social care teams and mental health teams also have responsibility for co-ordinating the action taken by organisations in response to concerns that an adult at risk is being, or is at risk of being, abused or neglected.

The local authority should:

- ensure that any Safeguarding Adults concern is acted on in line with this policy and procedure
- coordinate the actions that relevant organisations take in accordance with their own duties and responsibilities. This does not mean that local authorities undertake all activities under Safeguarding Adults – relevant organisations have their own roles and responsibilities
- ensure a continued focus on the adult at risk and due consideration to other adults or children
- ensure that key decisions are made to an agreed timescale

- ensure that an interim and a final protection plan are put in place with adequate arrangements for review and monitoring
- ensure that actions leading from investigation/assessment are proportionate to the level of risk and enable the adult at risk to be in control, unless there are clear recorded reasons why this should not be the case
- ensure independent scrutiny of circumstances leading to the concern and to Safeguarding Adults work
- facilitate learning lessons from practice and communicating these to partners.

Family, friends, and carers; who are not implicated in the allegation of abuse often have an important part to play in the Safeguarding Adults process, and can provide valuable support to the individual. In some cases they can also assist in managing the risk.
If appropriate and possible, and where the adult at risk has mental capacity and gives their consent, and there are no evidential constraints, family and friends should be consulted.
If the adult does not have mental capacity, family and friends must be consulted in accordance with the principles of the MCA 2005.
A record should be made of the decision to consult or not to consult family and friends with reasons being given and recorded.

Advocates: As part of the safeguarding process consideration should be given to whether an adult at risk may benefit from the support of an independent advocate. There are two distinct types of advocacy – instructed and non-instructed – and it is important that people involved in the Safeguarding Adults process are aware of which type of advocate is representing the person and supporting them to express their views.

Instructed advocates take their instructions from the person they are representing. For example, they will only attend meetings or express views with the permission of that person. Non-instructed advocates (IMCA's), work with people who lack capacity to make decisions about how the advocate should represent them. Non-instructed advocates independently decide how best to represent the person.
Advocates should be invited to the case conference (other than in exceptional circumstances e.g. where the relationship between the adult at risk and the advocate is considered abusive), either accompanying the adult at risk or attending on their behalf, to represent the person's views and wishes. Instructed advocates would attend only with the permission of the adult at risk.

'Managing officers' (there will be local name variations – see local guidance/policy) have a lead co-ordinating role in relation to individual cases. A managing officer must be informed of any safeguarding concern arising in any organisation and has overall responsibility for co-ordinating the Safeguarding Adults process.

The managing officer has overall responsibility to ensure that:

- The action being taken by organisations is co-ordinated and monitored
- The adult at risk is involved in all decisions that affect their daily life as far as possible
- Those who need to know are kept informed
- A decision is made in consultation with other relevant organisations to instigate the Safeguarding Adults process
- A multi-agency strategy meeting or discussion is held to determine how the Safeguarding Adults process will be conducted and who will conduct any

investigation, and that decisions are recorded and copied to relevant organisations
- The response of the organisations involved in the Safeguarding Adults process is co-ordinated: the aim is to agree that where indicated a joint investigation will take place with agreement to share information in line with the information- sharing protocol
- If required a multi-agency case conference is convened and chaired, a record made of the decisions taken and this information circulated to all relevant organisations
- If required a protection plan is agreed with the adult at risk if they have mental capacity to participate in this, or in the best interests of the person if they have been assessed not to have mental capacity
- All safeguarding documentation is completed including monitoring information.

Police: Every member of the community deserves protection from exploitation and abuse by those entrusted with their care and the people they should be able to rely on to keep them safe. The police should take any crime against an adult at risk seriously, and will investigate it thoroughly, professionally and empathetically. The police work very closely with partner agencies to ensure effective information sharing, risk assessment and decision-making takes place every time an incident of abuse is reported.

- The police will hold people causing abuse accountable for their actions. Where criminal proceedings are deemed inappropriate the police will work closely with partners to identify the most suitable course of action
- The police will work in effective partnership with other agencies to safeguard adults at risk
- Where a criminal offence appears to have been committed, the police will be the lead investigating agency and will direct investigations in line with legal and other procedural protocols. A police investigation will be initiated at the outset and a comprehensive initial risk assessment undertaken
- It is the responsibility of the police to secure and preserve evidence. The police will interview the alleged victim, the alleged person causing harm and any witnesses. Where the police are the lead investigating agency they will work closely with the local authority and other partner agencies in line with the Safeguarding Adults policy and procedures to ensure that the identified risks are acted on and a risk management or protection plan is agreed at an early stage
- There are now special measures that can be put into place to help vulnerable people through the court process. These measures have allowed many people who may once have been denied access to the criminal justice system the opportunity to give their evidence in court. The police will discuss these special measures with victims at the earliest stage possible in the investigation.
- Some adults at risk can be abused by strangers and the role of the police is to work in partnership with key agencies where a potential crime has been committed and on the development of a protection plan.

Associated Documentation

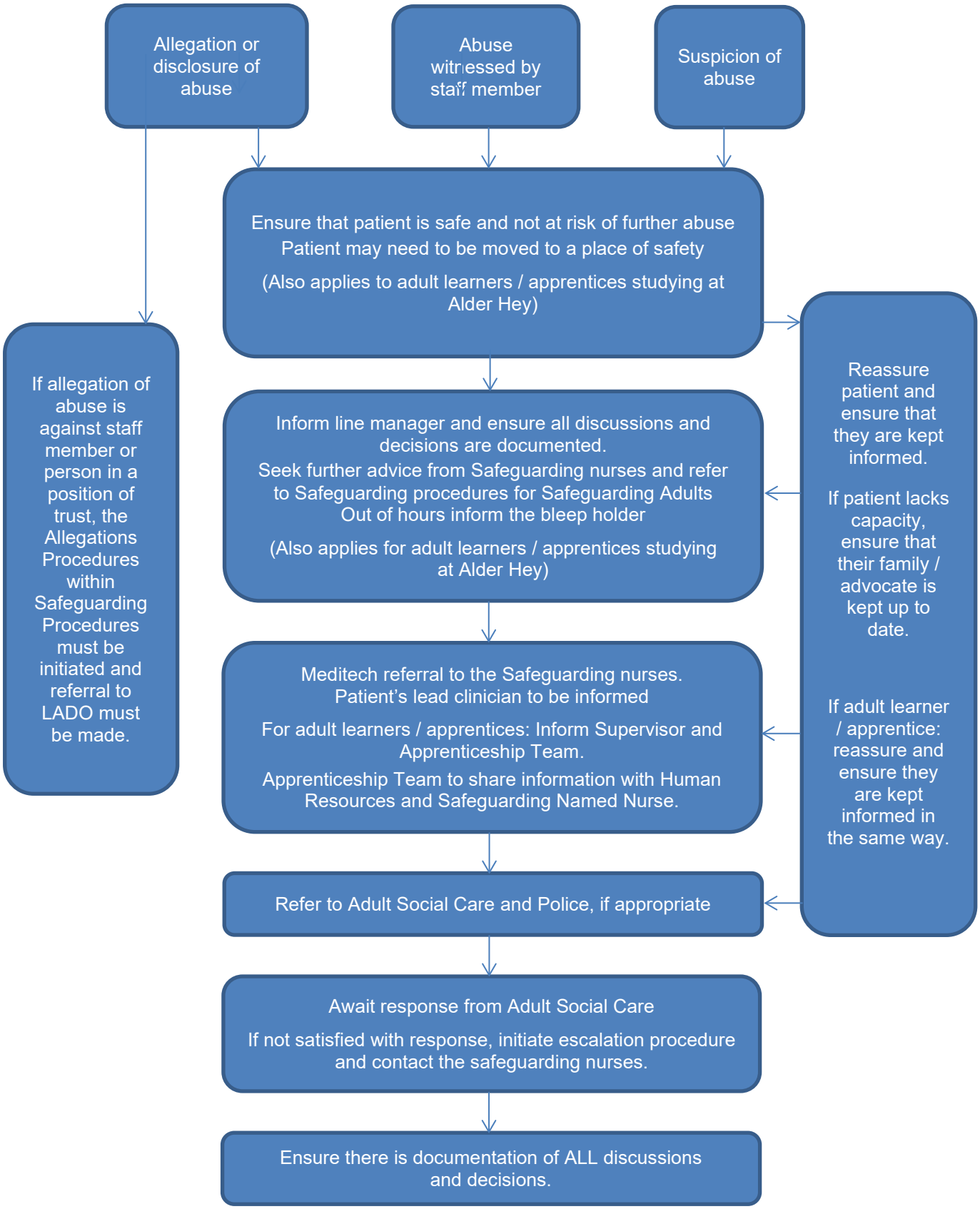
- **Procedures for the Safeguarding of Children and Adults at Risk of Abuse** (see DMS)
- Safeguarding Children Useful Information (Intranet Web Link)
- The UN Convention of the Rights of the Child 1990
- The European Convention of Human Rights/The Human Rights Act 1998
- Working Together to Safeguard Children 2018.
- Domestic Abuse a Resource Manual for Health Professionals 2004
- Safeguarding Children – A joint Chief Inspectors' Report on Arrangements to Safeguard Children
- Liverpool City Council – Inter agency safeguarding policy and procedures for the safeguarding for safeguarding adults at risk of abuse or neglect https://liverpool.gov.uk/referrals/adults-social-care-referrals-and-training/safeguarding-adults-procedure/
- Liverpool City Council Guidance for reporting a safeguarding concerns https://liverpool.gov.uk/media/1357207/guidance-for-reporting-a-safeguarding-concern-2018.pdf
- North West Safeguarding Adults Policy
- Alder Hey NHS Foundation Trust Statutory and Mandatory Training Policy
- Liverpool LSCB Thresholds document (2018)
- Deprivation of Liberty Safeguards A guide for hospitals and care homes
- Deprivation of Liberty Safeguards A guide for relevant person's representatives

In addition to this policy, the Trust has a number of policies and guidelines to provide the emotional support and physical safety of service users and staff members on the Document Management System (DMS) including:

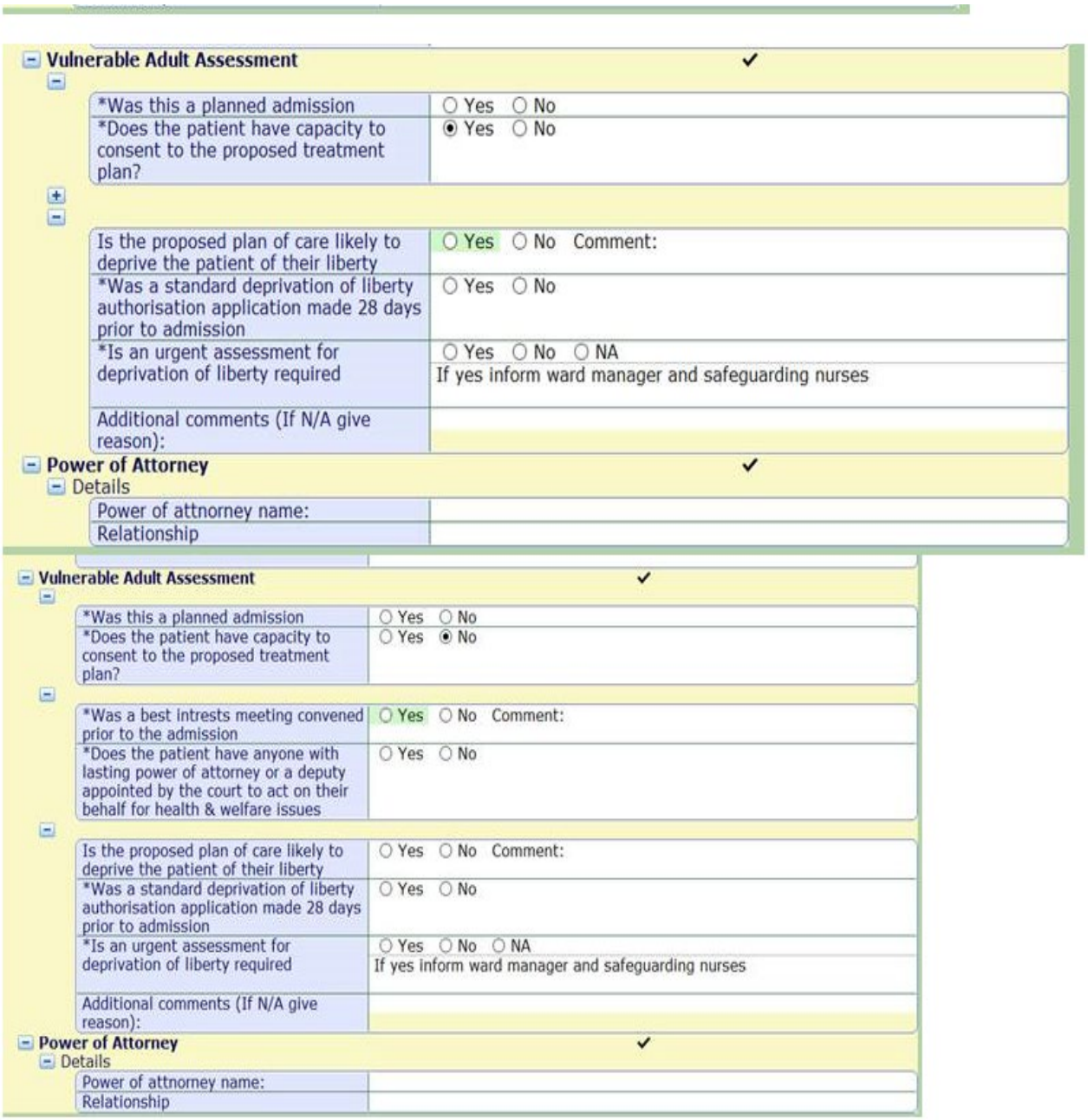
- Recruitment and Selection Policy – E2
- Data Protection Policy – RM44
- Whistleblowing Policy - E29
- Freedom of Information Policy – M25
- Grievance Policy – E7
- Disciplinary policy – E5
- Domestic Violence and Abuse Policy – M70
- Mental Capacity and DOLS Policy – M69
- The Management of Incidents Including the Management of Serious Critical Incidents Policy – RM2
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – RM9
- Privacy and Dignity Policy - C47
- Chaperoning Policy – C69
- Supporting Staff – E31
- Safe and Therapeutic Responses to Disturbed Behaviour Policy - MH2

Appendix B

Procedural Governance Flowchart for Suspected or Actual Abuse against an Adult Patient / Carer, Adult Learner or Apprentice



Appendix C



Vulnerable Adult Assessment ✓

*Was this a planned admission	○ Yes ○ No
*Does the patient have capacity to consent to the proposed treatment plan?	◉ Yes ○ No

Is the proposed plan of care likely to deprive the patient of their liberty	○ Yes ○ No Comment:
*Was a standard deprivation of liberty authorisation application made 28 days prior to admission	○ Yes ○ No
*Is an urgent assessment for deprivation of liberty required	○ Yes ○ No ○ NA If yes inform ward manager and safeguarding nurses
Additional comments (If N/A give reason):	

Power of Attorney ✓

Details

Power of attnorney name:	
Relationship	

Vulnerable Adult Assessment ✓

*Was this a planned admission	○ Yes ○ No
*Does the patient have capacity to consent to the proposed treatment plan?	○ Yes ◉ No

*Was a best intrests meeting convened prior to the admission	○ Yes ○ No Comment:
*Does the patient have anyone with lasting power of attorney or a deputy appointed by the court to act on their behalf for health & welfare issues	○ Yes ○ No

Is the proposed plan of care likely to deprive the patient of their liberty	○ Yes ○ No Comment:
*Was a standard deprivation of liberty authorisation application made 28 days prior to admission	○ Yes ○ No
*Is an urgent assessment for deprivation of liberty required	○ Yes ○ No ○ NA If yes inform ward manager and safeguarding nurses
Additional comments (If N/A give reason):	

Power of Attorney ✓

Details

Power of attnorney name:	
Relationship	

Interventions
Vulnerable Adults Assessment STAT ✔

Assessments
>18yrs Safegurading Trigger ✔
Safeguarding trigger list [P]

Click on 'P' icon for link to Safeguarding Intranet Page

If any concern is identified, please discuss with a senior nurse/clinician

*Inappropriate delay in presentation	○ Concern ○ No Concern
*Inconsistent history/injury	○ Concern ○ No Concern
*Previous multiple attendence	○ Concern ○ No Concern
*Inappropriate interaction: Patient/Parent/Carer	○ Concern ○ No Concern
*Medisec/CCI Alert	○ Concern ○ No Concern
*Does the attendance relate to a violent incident (Gun/Knife/Gang Culture)	○ Concern ○ No Concern
*Deliberate self-harm/ other risk taking behaviour (Alcohol, Drugs, Sexual Exploitation)	○ Concern ○ No Concern
*Non-Medical Alerts (CP plan,Rainbow,LAC,Medisec Letter,Summary of Alert)	○ Concern ○ No Concern
*Social Issues (Drugs/Alcohol/Mental Health/Domestic Violence)	○ Concern ○ No Concern
*Cultural Issues (FGM,Spiritual, Forced Marriage,Radicalisation)	○ Concern ○ No Concern

If any concern identified free text details here	
Do the concerns meet the threshold for a referral to Adult Services?	○ Yes ○ No
Is patient a vulnerable adult?	○ Yes ○ No
Patient in need of Early Intervention?	○ Yes ○ No
Have the appropriate referrals been completed?	○ Yes ○ No
Does the Patient require a Rainbow Examination?	○ Yes ○ No

Pleas give the name of the Lead clinician with Responsibility for referring child?	

Vulnerable Adult Assessment ✔

If any of the above concerns are identified: A RISK ASSESSMENT NEEDS TO BE UNDERTAKEN BY THE SENIOR NURSE AND REPRESENTATIVE FROM THE RISK MANAGEMENT TEAM.

Privacy and Dignity
This assessment must be completed for all in-patients aged 18 and over.

Has the individual been made aware of the Trusts commitment to Respect their Privacy and Dignity?	○ Yes ○ No Comment:
Has the individual been made aware of the need to respect the Privacy and Dignity of other patients?	○ Yes ○ No Comment:
Is the patient being nursed in a single room with bathroom?	○ Yes ○ No

If NO please give reason and Management Strategy:	

Information

Has the individual been asked to share information in relation to possible risk they may pose to children?	○ Yes ○ No Comment:
From the information shared during the assessment, is it considered that the patient poses a potential risk to other children and young people?	○ Yes ○ No

If YES, please give details:	
Has the Safeguarding Nurse been informed?	○ Yes ○ No Comment:
Has a Security Specialist been informed?	○ Yes ○ No Comment:
Has a Risk Assessment been completed?	○ Yes ○ No Comment:

Things Staff need to Consider:

Staff need to consider if the individual requires any additional support to minimise a potential risk to themselves and other patients.

Does the individual have a physical impairment?	○ Yes ○ No Comment:
Does the individual have any language difficulties?	○ Yes ○ No Comment:
Does the individual have a history of substance misuse?	○ Yes ○ No Comment:
Does the individual have a history of self harm?	○ Yes ○ No Comment:
Is the individual prone to aggressive behaviour or violent outbursts?	○ Yes ○ No Comment:
Is the individual known to have a history of sexualised behaviour?	○ Yes ○ No Comment:
Any other issues?	○ Yes ○ No Comment:
Has the individual disclosed any information that would indicate they pose a specific risk to children: (All)	☐ A person who is known to be violent ☐ A person who's been cautioned/convicted of an offence against a child ☐ A person who is known to sign the Sex Offender's Register ☐ A person who is known to use illicit drugs ☐ N/A ☐ Other
If 'Other' please Specify:	

Things Staff need to Consider:

Staff need to consider if the individual requires any additional support to minimise a potential risk to themselves and other patients.

Does the individual have a physical impairment?	○ Yes ○ No Comment:
Does the individual have any language difficulties?	○ Yes ○ No Comment:
Does the individual have a history of substance misuse?	○ Yes ○ No Comment:
Does the individual have a history of self harm?	○ Yes ○ No Comment:
Is the individual prone to aggressive behaviour or violent outbursts?	○ Yes ○ No Comment:
Is the individual known to have a history of sexualised behaviour?	○ Yes ○ No Comment:
Any other issues?	○ Yes ○ No Comment:
Has the individual disclosed any information that would indicate they pose a specific risk to children: (All)	☐ A person who is known to be violent ☐ A person who's been cautioned/convicted of an offence against a child ☐ A person who is known to sign the Sex Offender's Register ☐ A person who is known to use illicit drugs ☐ N/A ☐ Other
If 'Other' please Specify:	

Appendix D - Safeguarding Adults Clinical Supervision

1 Introduction

1.1 Clinical supervision is a term used to describe a formal process of professional support and learning which enables practitioners to develop knowledge, skills and competence, assume responsibility for their own practice and enhance patient/client protection and safety of care in complex situations.

1.2 Safeguarding clinical supervision should be provided by an experienced, appropriate senior professional, who has received supervision themselves and undertaken specific training or development to equip them with the skills to clinically supervise.

1.3 Safeguarding clinical supervision entails reviewing the practitioners' Safeguarding cases, discussing cases of suspected abuse and monitoring records to ensure that all the information about a the adult is reviewed.

1.4 Safeguarding clinical supervision should be provided where there is an on-going long-term duty of care for an Adult patient.

1.5 The Trust provides health care services to Adults with very complex medical and nursing needs, who may have been known to professionals for many years. Professionals who are involved in individual cases may be affected by the stressful nature of this work. In these situations the Safeguarding Team will provide clinical supervision as requested.

1.6 Formal records of the safeguarding clinical supervision should be used and kept in the patient's records and also the supervisors' record.

2. Outcomes of Safeguarding Clinical Supervision

2.1 Safeguarding clinical supervision should develop the practitioner to be able to;

- Reflect and record the discussions
- Be clear about the issues presented by the case
- Be clear about the adult's health needs
- Be clear about the legislative framework of the case
- Have a clear written action plan/care plan for their work with the adult, their family and relevant other professionals and agencies.
- Record the action/care plan in the patient records
- Have good practice confirmed and feels supported in their practice
- Ensure formal reviewing of the cases

3. Guidelines for All Health Professionals

3.1 If the duty of care is short term then safeguarding clinical supervision will be provided on request.

3.2 If the duty of care will be an on-going long-term arrangement (over 4 months) then the line manager should arrange clinical supervision appointments with the nurse or allied health professional

3.3 The health professional and the line manager should take joint responsibility to ensure that the supervision takes place between these time scales and use appropriate Trust record keeping systems and documentation (see appendices).

3.4 A copy of the safeguarding supervision form should be placed in the adult's records a copy kept by the supervisor and a copy sent to the Safeguarding Nursing Team.

3.5 The Safeguarding Nursing Team can be contacted for advice and support in respect of Safeguarding clinical supervision. In some cases it may be appropriate for the Safeguarding specialist team to undertake the role of Supervisor in safeguarding clinical supervision.

4.2 The Named Doctor for Safeguarding can also offer individual supervision to any member of medical staff.

4 Supervision for Specialist Safeguarding Team

4.1 The Associate Director for Safeguarding, Named Nurse for Safeguarding and the Named Dr for Safeguarding can access formal supervision from the Designated Professionals for Liverpool.

4.2 The Associate Director for Safeguarding provides at least quarterly individual supervision to the Named Nurse for safeguarding Adults.

4.3 The Named Nurse provides at least quarterly individual supervision to the Specialist Safeguarding Team. Additional supervision can be arranged as required.

4.4 The Safeguarding Specialists provide bimonthly group supervision to all departmental safeguarding link nurses/champions. There is also the provision of individual supervision if requested.

4.5 The Safeguarding Specialist team offer reactive and planned supervision for any staff member who requests safeguarding supervision. There is drop in session each Tuesday between 12 and 1pm for staff to book a supervision session.

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form		
Policy Name	Safeguarding Adults Policy	
Policy Overview	The Trust's Safeguarding Adults Policy and associated Safeguarding Procedures will provide staff with detailed guidance on how to safeguard adult patients and recognise and respond to concerns. The Trust recognises that it has a duty to ensure that all staff involved in the direct care of adult patients, understand the importance of safeguarding and have knowledge of the relevant legislation and guidance that governs the welfare of vulnerable adults. The policy will advocate that all staff that has contact with vulnerable adults should understand the predisposing factors, signs and indicators of abuse and will be able to exercise professional skill in terms of effective information. In addition staff will have the knowledge and skills to understand the importance of information sharing and making timely and appropriate referrals and they will also be able to escalate their concerns within the organisation, and collaborate with other agencies and disciplines in order to safeguard vulnerable adults	
Relevant Changes (if any)	Click here to enter text.	
Equality Relevance Select LOW, MEDIUM or HIGH	HIGH	
If the policy is LOW relevance, you **MUST** state the reasons here.	Click here to enter text.	
Form completed on:	Date: 27/10/2021	
Form completed by:	Name: Cath Creed	Job Title: Named Nurse for Safeguarding Children, Young People and Adults

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted.	Protected Characteristic	Mitigation
	Age ☑ How: This policy pertains to patients over the age of 18 years	Click here to enter text.
	Disability ☑ How: Click here to enter text.	This policy will be particularly relevant to adult patients who

(use **Equality Relevance** to assess the impact on each protected characteristic)		suffer from physical disability and/or learning disability. The Trust has a duty to protect all adults and recognises that those with a disability are at increased risk of abuse. The policy will provide details of the specific processes to be initiated if the patient lacks capacity in order to ensure that decisions taken regarding care and treatment are in the best interests of the patient. See Section 7 Mental Capacity and Section 6 Deprivation of Liberty Safeguards
	Gender reassignment ☑ How: Click here to enter text.	The Trust pays due regard to the elimination of discrimination, harassment and victimisation of transgender / transsexual service users and endeavours to advance equality and to foster good relations between transsexual people and others.
	Marriage & Civil Partnership ☑ How: Click here to enter text.	The policy will ensure that staff recognise that forced marriage is illegal and that staff must report any concerns they have that an individual is being forced or coerced into marriage against their will
	Pregnancy or Maternity ☐ How: Click here to enter text.	Click here to enter text.
	Race ☑ How: Click here to enter text.	The policy refers to the illegal practice of Female Genital Mutilation (FGM) section 3.35. Health service staff are well placed to identify report and support patients who have been or who are potential victims of FGM. FGM is a form of abuse and therefore must be reported
	Religion or Belief ☑ How: Click here to enter text.	The policy may challenge the cultural beliefs / practices of some service users for example FGM
	Sex ☐ How: Click here to enter text.	Click here to enter text.

	Sexual Orientation ☐ How: Click here to enter text.	Click here to enter text.
	Human Rights (FREDA principles) ☑ How: Click here to enter text.	This policy will apply the FREDA principles, Fairness, Respect, Quality, Dignity and Autonomy, and is related to all adult patients over the age of 18, including those patients with disability and may also lack mental capacity. FREDA principle 1: All patients will be treated fairly, having the same access to health care and planning. Plans of care will be designed around the individual needs of each patient using a person centred approach. FREDA principle 2 & 4: All patients will be cared for with respect and dignity. Plans will include the services of the Transitional Care Team and will be person centred, and ensure that patients, their families and carers feel empowered and supported. All patients and families will be treated with the highest of respect and given the best possible care, tailored around their health, educational, social, emotional, psychological, physical and cultural needs. FREDA principle 3: All patients will have a vulnerability assessment at each admission. Staff will ensure that appropriate referrals to the Trust Transitional care Team are made. Patient and family satisfaction will be monitored, by the Trust which will include identification of compliance with quality and equality standards 5: Patients will be empowered (where they have capacity) and supported to manage their' health care, promoting self-management and

		independence. When patients lack capacity The Trust will ensure that the Best Interests Process is initiated
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	The vulnerable adults safeguarding policy has been informed by National Guidance and Legislation, including the Local Safeguarding Adults Board. Fundamental to the safeguarding Adult agenda is the inclusion of Deprivation of Liberty processes. Refer to section 17 of the Policy but in particular Mental Capacity Act (2005) http://www.legislation.gov.uk/ukpga/2005/9/contents Council of Europe, (2002) "Safeguarding adults & children with disabilities against abuse." http://www.coe.int/t/e/social_cohesion/soc-sp/Abuse%20_E%20in%20color.pdf Department of Health, (2000). "No Secrets HSC 2000/007: Guidance on developing multi-agency policies and procedures to protect vulnerable adults from abuse." City of Liverpool Safeguarding Adults (2013): "A Framework for Action" http://liverpool.gov.uk/media/102189/safeguarding-policy-february-2013.pdf Sefton Council (2015): Sefton Adults Executive Board "Sefton Safeguarding Adults Framework for Action" https://www.sefton.gov.uk/media/566940/sab_framework-for-action-2015.pdf Nursing and Midwifery Council, (2015) "Code of Professional Conduct." **HM Government, (2018)"***Working together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children."* **DoH (2018)** "Care and Support Statutory, Guidance Issued under the Care Act 2014," Procedures for the Safeguarding of Children and Vulnerable Adults No gaps have been identified	
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See **Gunning Principles** for public consultation requirements. **How has consultation influenced the policy?**	Consultation regarding the content of this policy has been made with the following professional groups: •Alder Hey Safeguarding Governance Board •Merseyside CCG Designated Nurses for Safeguarding Adults •Alder Hey Transition Service •National tertiary Named Nurse Network •A number of Local Adult safeguarding leads •Adult Social care •Named Nurse for Merseycare Following consultation the Trust has developed closer links with Adult Services and developed a training strategy for staff	

	which will ensure that key professionals are aware of the procedures to be implemented when adult patients are admitted to the Trust
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	This policy will impact positively and support the existing safeguarding children policy and associated procedures. It will assist trust staff to identify and respond appropriately to all safeguarding adult concerns. This policy will also impact positively and support the following policies to ensure that our most vulnerable adult patients are free from abuse and neglect when in our care and that our staff are aware of their duty to report any safeguarding concerns they have regarding their patients •Safeguarding Children policy & procedures •Records management and information policy •Being open – Duty of Candour policy •Privacy & dignity policy •Management of Patient Flow policy •Equality, Diversity & Human Rights policy •Transition to Adult Services policy •Advanced Care Planning policy •Adult Patient Information Leaflet •Vulnerable Adult Assessment Tool •Deprivation of Liberties Assessment Tool
Public Sector Equality Duty Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	a) Eliminate discrimination, harassment, victimisation etc Click here to enter text.
	b) Advance equality of opportunity Click here to enter text.
	c) Foster good relations Click here to enter text.
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐ This policy is intended to impact positively on all vulnerable adult patients. The policy will closely support the Transition process and ensure a seamless handover of care to adult services. It aims to safeguard and promotes joint working for the benefit of all vulnerable adult patients. Audit of this policy will be undertaken to establish the inclusivity of this policy, to ensure the policy mitigates negative equality impact on patients who have other protected characteristics.
Monitoring Include details of how the equality impact will be monitored.	Continuous monitoring of the effectiveness of this policy will be undertaken by the safeguarding nursing team who are routinely informed of all adult patient admissions and will quality assess the information provided in the referral and ensure that all necessary assessments have been undertaken. Monitoring will also include the identification of complex patients and those patients who lack capacity, to ensure they are effectively safeguarded. This will consist of a Case Review Audit of five adult patients per quarter to ascertain - •Were appropriate internal assessments undertaken •Were appropriate external / multi agency / specialist assessments undertaken •Were LASB procedures followed •Was the appropriate documentation completed

Review of Equality Analysis (if indicated)	Rationale for review: Click here to enter text.	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If **MEDIUM** or **HIGH r**elevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Cath Creed	Job title: Named Nurse for Safeguarding Children, Young People and Adults
Approval Committee:	Community Policy and Procedures Sub-Group	Date approved: 03/11/2021
Ratification Committee:	Clinical Quality Steering Group	Date ratified: 09/11/2021
Person to Review Equality Analysis:	Name: Cath Creed	Review Date: 09/11/2024
Comments:	Click here to enter text.	

Alder Hey Children's
NHS Foundation Trust

M3 – SAFEGUARDING CHILDREN POLICY

Version:	9
Ratified by:	Clinical Quality Steering Group
Date ratified:	09/11/2021
Name of originator/author:	Julie Knowles/Cath Creed
Approved by:	Community Policies and Procedures Sub-Group
Date approved:	02/11/2021
Executive Sponsor:	Chief Nurse
Key search words:	Child Protection, vulnerable adult, safeguarding, M3
Date issued:	November 2021
Review date:	November 2024

Quick Reference Guide – Safeguarding Children Policy

This policy applies to all Trust staff.

KEY MESSAGES

For the purpose of this policy the term "child" will apply to all those aged 0-18 years.

The Trust has a **Safeguarding Adults Policy (M3A)** which is accessible via the Policies and Guidance Section on the Trust Intranet.

The Trust has a duty to ensure that all staff involved in the direct care of patients, understand the importance of safeguarding and promoting the welfare of children and vulnerable adults to ensure that all patients receive appropriate and timely therapeutic and preventative interventions.

The Trust's Safeguarding Policy and the associated **Safeguarding Procedures** (see DMS) gives detailed guidance to all staff on how to respond to a range of safeguarding issues and make appropriate and timely referrals.

All Trust staff who have contact with children should have knowledge of the predisposing factors, signs and indicators of abuse. They should be able to exercise professional skill in terms of effective information sharing and the ability to analyse this information. They should also have the knowledge and skills to collaborate with other agencies and disciplines in order to safeguard the welfare of children.

KEY RESPONSIBILITIES

Trust Board

The Board has ultimate responsibility for ensuring that an effective system for managing any risks associated with safeguarding children and young people exists within the Trust and that all staff working in the Trust are aware of and operate within the policy. The Board will assure itself of compliance with this policy through the accountability arrangements delegated to the Clinical Quality Steering Group and via consideration of an annual report prepared by the Safeguarding Lead.

Chief Nurse

The Chief Nurse is the Trust Board member with individual responsibility for ensuring that a policy and procedure for effective safeguarding of children and young people exists; that it is implemented effectively; that all staff are aware of and operate within the requirements of the policy and that systems are in place for the effective monitoring of the standards contained within the policy.

Clinical Quality Steering Group

The Clinical Quality Steering Group is an established part of the governance structures of the Trust which has the responsibility to ensure that safeguarding of children, young people and their family arrangements are managed appropriately across the organisation. The Committee ensures that the policy framework is appropriate and receives assurances in relation to compliance with the requirements of this policy through receipt of reports, audit activity.

Assistant Director, Named Nurse and Named Doctor for Safeguarding

The Named professional's for safeguarding hold responsibility to lead on all aspects of the Trust contribution to the safeguarding of children, young people and their families and the promotion of their welfare within Alder Hey. The Named professionals will support the AD for safeguarding in assuring the Board that a high-quality evidence-based safeguarding

service is being provided within Alder Hey NHS Foundation Trust. They will provide professional and clinical leadership and be a source of expertise on matters relating to safeguarding children and young people for the Trust, local healthcare providers and other local agencies and organisations. They have the day-to-day operational responsibility for safeguarding children and young people.

Trust Safeguarding Team

The Safeguarding Team provide training, consultancy and advice on all matters related to adult and children's safeguarding issues and members of the Team are available as a Trust resource for practitioners, service users and their carers, Monday to Friday 09.00-17.00. Out of hours at weekends and up until midnight seven days a week, staff should contact the bleep holder or the on-call consultant for safeguarding.

Line Managers

Ensure that all staff members are aware of the Trust Safeguarding Policy and Procedures together with their individual role in safeguarding and promoting the welfare of all children and vulnerable adults.

Ensure all staff members receive the role specific training and supervision needed to recognise and act upon safeguarding concerns and respond to the needs of children or vulnerable adults.

Ensure all staff have easy access to the Trust Policy and Procedures

Medical Staff

Must maintain their skills in the recognition of abuse and be familiar with the procedures to be followed if abuse and or neglect is suspected.

Individual Staff Members

All health professionals working directly with children or vulnerable adults should ensure that safeguarding and promoting welfare forms an integral part of all stages of care delivery and do this in accordance with the Trust's Safeguarding Policy and procedures.

Must respond appropriately to safeguarding concerns and make appropriate and timely referrals

Must follow appropriate procedures in finding out if a child is subject of a Child Protection Plan, is a Looked After Child or has an allocated Social Worker

Must respond to requests by Children's / Adult Social Care or other agencies regarding safeguarding children and vulnerable adult issues.

Participate in specific types of assessment and any other role required for multi-agency working to safeguarding children and vulnerable adults.

Make timely, appropriate referrals to the Trust safeguarding team and relevant multi agencies.

All lone workers must adhere to the **Preventing and Managing Violence and Aggression at Work and Lone Worker Policy - RM9** (see DMS) in order to reduce or eliminate any potential risk to themselves.

The apprenticeship team should use Procedural Flowchart and **Safeguarding Procedures** (see DMS) if an adult learner or apprentice discloses abuse or abuse is suspected

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
9	November 2021	Cath Creed/Julie Knowles	Current	Review of Policy and amendments made as necessary
8.1	July 2019	Julie Knowles	Archived	
8	October 2018	Julie Knowles	Archived	Annual review undertaken as part of commissioning arrangements formal 3 yearly review brought forward
7.1	August 2017	Julie Knowles	Archived	Annual review undertaken as part of commissioning arrangements
7	January 2016	Julie Knowles	Archived	
6	April 2013	Julie Knowles	Archived	Review of Policy and amendments made as necessary
5	January 2012	Julie Knowles	Archived	Review of Policy and amendments made as necessary
4	July 2010	Julie Knowles	Archived	Associated procedures changed to encompass new SUDI protocol
3	December 2009	Julie Knowles	Archived	
2	October 2006	Julie Knowles	Archived	
1	May 2004	Tilly Jones	Archived	

Child Protection Procedures				
0	October 1998	Unknown	Archived	Renamed as Child Protection Policy
Policy and Procedure for Nursing Staff Requested to give Patient Information and /or a Statement to a Member of the Police Force.				
0	March 1998	Unknown	Archived	Incorporated into Child Protection Policy
Recommendations for Procedures if Known Schedule 1 Offenders are Admitted or Visit Alder Hey Children's Hospital				
0	April 1996	Unknown	Archived	Incorporated into Child Protection Policy
Nurse Attendance at Child Protection Conferences				
0	March 1995	Unknown	Archived	No longer a Trust policy. Dealt with by PCT
Identification by Blue Spot of Hospital Medical Records of Children on Liverpool's and South Sefton Child Protection Register				
0	March 1995	Unknown	Archived	Incorporated into Child Protection Policy
Monitoring of records for a child on the child protection register				
0	March 1995	Unknown	Archived	Incorporated into Child Protection Policy
Record keeping for a child on the child protection register				
0	March 1995	Unknown	Archived	Incorporated into Child Protection Policy

Record of changes made to Safeguarding Policy – Version 9			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Quick reference guide	2	All Staff and Trust Board responsibilities expanded upon and updated to reflect current roles across the Trust Addition of clinical quality steering group	Increase clarity regarding roles and responsibilities across the Trust regarding safeguarding
1.3	7	Re-worded paragraph to include wider family	To reflect Think Family approach to safeguarding
4.2	9	Addition of Domestic Abuse Act 2021	To reflect updated safeguarding law
4.3	9	Working Together reference replaced Lord laming reference	Updated statutory guidance
4.7	10	Inclusion of apprentices in staff members	Reflective of adult learners within the Trust
5.0	11	Line included- or know who to contact to support them in completing safeguarding duty	To ensure that staff members who may not be familiar with processes understand who to contact to get safeguarding support
5.3	11	Removal of reference to mandatory training policy (duplicate) and insertion of Intercollegiate Framework reference	To reflect safeguarding TNA and standards for the delivery and content of safeguarding training
8	12	Policy and procedure links updated and amended	To reflect updated policy and safeguarding law

Contents

1 Introduction

1.1 Every child deserves the opportunity to achieve their full potential. The safety and health of a child are intertwined aspects of their wellbeing and staying safe, being protected from harm or neglect has been identified as one of the five outcomes set out by the Government that are key to children and young people's well-being. Child protection is a part of the safeguarding agenda and all health professionals working directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer.

1.2 Safeguarding and promoting the welfare of children has been defined by Working Together to Safeguard Children (2018)[1] as:

- Protecting children from maltreatment;
- Preventing impairment of children's health or development;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes

1.3 The Trust has a duty to ensure that all staff involved in the patient's direct care, understand the importance of safeguarding children, young people and their families to ensure that anyone who may have or has experienced abuse receives appropriate and timely therapeutic and preventative interventions.

1.4 The Trust Safeguarding Children Policy, Safeguarding Adults Policy and the Trust's Safeguarding Procedures comply with all National and Local policy guidance including;

- The Children Act 1989[2],
- The Children's NSF (2004)
- The Children Act 2004[6],
- Working Together to Safeguard Children (2018)
- No secrets (DOH 2000)
- Local Safeguarding Children Partnership (LSCP) Safeguarding Interagency procedures
- Building Partnerships, Staying Safe - The health sector contribution to HM Government's *Prevent* strategy: guidance for healthcare organisations
- The Domestic Abuse Act 2021
- The Care Act 2014
- Merseyside safeguarding adults board multi agency policies and procedures

1.5 **Aims**

i. This policy and associated Safeguarding procedures aims to assist all Trust staff with their different safeguarding responsibilities

ii. This Policy and associated procedures would enable staff to respond appropriately to all safeguarding concerns and make appropriate and timely referrals. (In accordance with the associated Safeguarding Children Procedures[8])

2 Purpose

2.1 To give all staff guidance on how to respond to a range of safeguarding issues.

2.2 Policy Statement

The Trust has a duty to safeguard and promote the welfare of children and must ensure that all staff who come into contact with children and their families will do this in accordance with the policy and guidance procedures set out below. All Trust personnel must therefore;

- Follow the Manual of Safeguarding procedures accessed via the Policies and Guidelines section on the Staff Intranet
- Use the associated documentation where relevant
- Attend the mandatory safeguarding training specific to role – see Safeguarding Section of the intranet for links to training.
- Be familiar with the Trust safeguarding web resource available to all staff via the Trust Intranet

3 Definitions:

3.1 Safeguarding and promoting the welfare of children, for the purpose of this guidance is defined as:

- protecting children from maltreatment
- preventing impairment of children's health and development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- undertaking that role to enable those children to have optimum life chances and to enter adulthood successfully

These aspects of safeguarding and promoting the welfare of children are cumulative and contribute to the five outcomes that are key to ensuring the wellbeing of children and young people.

3.2 Definition of Adult: A person who, by virtue of attaining the age of eighteen, is regarded in law as being able to manage his or her own affairs.

3.3 Definition of Adult Safeguarding: Prior to Care Act 2014 adult safeguarding referred to vulnerable adults, which was defined as: —any person over the age of 18 who is, or may be in need of, care services by reason of mental or other disability, age or illness, and who is, or may be unable to take care of themselves or is unable to protect themselves against harm or exploitation‖ (law commission, 1995).
However the Care Act 2014 redefined safeguarding duties as applying to an adult who has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

3.4 The Department of Health published "Care and support statutory guidance" (June 2017) to provide assistance on use of the Care Act which includes information specific to safeguarding (supporting section 42-46 of the Act):

The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25. Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners (for example, the Police or NHS) or other persons relevant to the case. However, the level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under the Care Act or be receiving any particular service from the local authority, in order for the safeguarding duties to apply.

4 Duties

4.1 All organisations that work with children share a commitment to safeguard and promote their welfare. In addition, all NHS Trusts, under Section 11 of the Children Act 2004[6] have a duty to safeguard and promote the welfare of children. The Care Quality Commission will ensure that NHS Organisations adhere to their legal responsibilities under Essential Standards of Quality and Safety (2010) and that organisational functions are discharged regarding the need to safeguard and promote the welfare of children.

4.2 The Government has placed the issue of adult protection on the political agenda. The issue has been highlighted in recent Acts of Parliament and Government guidance documents, most notably: Youth Justice and Criminal Evidence Act 1999[12], Crime and Disorder Act 1998[13], Modernising Social Services: Making Decisions: Action for Justice: Living Without Fear: Caring for Young People and Vulnerable Adults; Achieving Best Evidence: No Secrets and more recently The Domestic Abuse Act 2021.

4.3 The Trust Management Board

i. Must co-operate with the Local Authority in the operation of the LSCB, and as statutory partners, share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children and vulnerable adults.

ii. The Chief Nurse takes the lead role for the Trust in relation to Safeguarding and promoting the welfare of children and is the named Executive Board member for safeguarding.

iii. Must ensure safeguarding is an integral part of the Trust governance scheme.

iv. Ensure their employees are aware of how to recognise and respond to safeguarding concerns, including signs of possible maltreatment.

v. Must ensure that all staff are informed of and follow Trust safeguarding policy and procedures.

vi. Must ensure all statutory guidance including Working Together to Safeguard Children 2018 are implemented and monitored for compliance within the Trust.

4.4 **Named Doctor / Named Nurse for Safeguarding**

i. Must support and advise the Trust in all activities necessary to ensure that the Trust meets its responsibilities in safeguarding children and adults.

ii. The Named professionals have a key role in promoting good professional practice within the Trust and provide advice and expertise for fellow professionals.

iii. Must advise the Trust Board (via the Executive Nurse) of their responsibilities to ensure that the performance indicators in relation to safeguarding are met.

iv. Ensure that the Trust has appropriate safeguarding policies and procedures which comply with National and Local Safeguarding Children's Board guidance. Additionally, to ensure that procedures are distributed, understood and implemented throughout the Trust.

v. Ensure that the Trust has (in accordance with national policy) an appropriate training strategy for safeguarding and protecting children and adults.

vi. Take an active role in seeing children where there are safeguarding concerns, in partnership with the relevant Trust staff.

vii. Support and advise other professionals on the management of all types of child maltreatment.

4.5 **Line Managers**

i. Ensure that all staff members are aware of the Trust Safeguarding Policy and procedures together with their individual role in safeguarding and promoting the welfare of all children..

ii. Ensure all staff members receive the role specific training and supervision needed to recognise and act upon safeguarding concerns, and respond to the needs of children.

iii. Ensure all staff have easy access to the Trust Policy and Procedures

4.6 **Medical Staff**

i. All Trust medical staff must maintain their skills in the recognition of abuse, and be familiar with the procedures to be followed if abuse and or neglect is suspected.

4.7 **Individual Staff Members**

i. All health professionals working directly with children should ensure that safeguarding and promoting welfare forms an integral part of all stages of care delivery and do this in accordance with the Trust's Safeguarding Policy and procedures.

ii. Must respond appropriately to safeguarding concerns and make appropriate and timely referrals

iii. Must follow appropriate procedures in finding out if a child is subject of a Child Protection Plan, a Child in Need Plan is a Looked After Child or has an allocated Social Worker or Key Worker.

iv. Must respond to requests by Children's Social Care or other agencies regarding safeguarding children issues.

v. Participate in specific types of assessment and any other role required for multi-agency working to safeguard children.

vi. Make timely, appropriate referrals to the Trust safeguarding team and relevant multi agencies.

vii. All lone workers must adhere to the **Preventing and Managing Violence and Aggression at Work and Lone Worker Policy - RM9** (see DMS) in order to reduce or eliminate any potential risk to themselves.

viii. The apprenticeship team should use Procedural Flowchart and Safeguarding Procedures if an adult learner or apprentice discloses abuse or abuse is suspected

5 Training

5.1 All Trust staff who have contact with children and adults should have knowledge of the predisposing factors, signs and indicators of abuse. They should be able to exercise professional skill in terms of effective information sharing and the ability to analyse this information. They should also have the knowledge and skills to collaborate with other agencies and disciplines in order to safeguard the welfare of children and adults or know who to contact to support them with this duty.

5.2 Staff must be trained according to their role and responsibility and the degree of contact they have with children and young people as defined in the Training Needs Analysis (See **Mandatory Training Policy – E21** on DMS).

5.3 All staff will be trained inline with Intercollegiate Framework Document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Jan 2019) https://www.rcn.org.uk/professional-development/publications/pub-007366

6 Arrangements for Managing the Risks Associated with Caring for Adult Patients in a Children's Hospital.

6.1 Please refer to the Trust **Safeguarding Adults Policy - M2** (see DMS) for guidance in relation to safeguarding adult issues.

7 Monitoring

7.1 Safeguarding Key Performance Indicators (KPIs) are agreed with commissioners and form part of the Quality Contract. Compliance with KPIs is reported to commissioners on a quarterly basis and discussed at the joint Clinical Quality Performance Group (CQPG) meeting.

7.2 An Annual Safeguarding Report will be presented to the Trust's Clinical Quality Steering Group, which will include:

- Local arrangements for managing safeguarding of children and adults within the Trust
- Training compliance
- Results of safeguarding audits
- Process for supporting staff involved in safeguarding issues

8 Further Information

References

1 HM Government Working Together to Safeguard Children (2018)[1]
2 The Children Act 1989[2],
3 The Victoria Climbie Inquiry – Laming Report (2003) [3],
4 Every Child Matters-Change for Children 2004[4],
5 The Children's NSF (2004) [5]
6 The Children Act 2004[6],
7 No Secrets DOH (2000) [7]
8 Local Safeguarding Children partnership (LSCP) Multi agency safeguarding procedures https://liverpoolscp.proceduresonline.com/chapters/contents.html#managing
9 Merseyside safeguarding Adults Board Procedures https://www.merseysidesafeguardingadultsboard.co.uk/procedures/adults-procedures/
10 Building Partnerships, Staying Safe - The health sector contribution to HM Government's *Prevent* strategy: guidance for healthcare organisations
11 Community Care Act (2003)
12 Youth Justice and Criminal Evidence Act (1999)
13 Crime and Disorder Act (1998)
15 Care and support statutory guidance. Updated 28 June 2017. DoH
16 Faltering Growth: Recognition and management of faltering growth in children NICE Guideline (NG75)
17 Child Abuse and Neglect NICE Quality Standard (QS179)

Associated Documentation (see DMS for Trust Policies and Procedures)

- Safeguarding Procedures
- Trust Safeguarding Adults Policy - M3
- Domestic Abuse and Violence Policy - M70
- Mental Capacity and DoLS Policy - M69
- Looked After Children Policy - M65
- Looked After Children SOPs and Pathways for best practice
- PREVENT Policy - RM19
- Safeguarding Children Useful Information (Staff Intranet)
- The UN Convention of the Rights of the Child 1990
- The European Convention of Human Rights/The Human Rights Act 1998
- Safeguarding Children – A joint Chief Inspectors' Report on Arrangements to Safeguard Children
- Local Safeguarding Children Partnership (LSCP) Inter Agency Procedures Manual: https://liverpoolscp.proceduresonline.com/
- Liverpool Safeguarding Adults Board (LSAB) https://liverpool.gov.uk/adult-social-care/keeping-adults-safe/safeguarding-adults-board/
- Liverpool City Council-safeguarding Adults procedure https://liverpool.gov.uk/referrals/adults-social-care-referrals-and-training/safeguarding-adults-procedure/
- Alder Hey Mandatory Training Policy – E21
- Liverpool LSCP Responding to Need Guidance and levels of need framework https://liverpoolscp.org.uk/scp/lscp-levels-of-need/lscb-responding-to-need
- Deprivation of Liberty Safeguards A guide for hospitals and care homes
- Deprivation of Liberty Safeguards A guide for relevant person's representatives
- Domestic Abuse Act 2021

In addition to this policy, the Trust has a number of policies and guidelines to provide the emotional support and physical safety of service users and staff members including:

- Recruitment and Selection Policy – E2
- Data Protection Policy – RM44
- Freedom of Information Policy – M25
- Grievance Policy – E7
- Disciplinary Policy – E5
- The Management of Incidents Including the Management of Serious Critical Incidents Policy – RM2
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – RM9
- Privacy and Dignity Policy - C47
- Chaperoning Policy – C69
- Supporting Staff Policy – E31
- Preventing and Managing Violence and Aggression at Work Zero Tolerance Process and Protecting Lone Worker Policy - RM9

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form		
Policy Name	Safeguarding Children Policy	
Policy Overview	The Trust's Safeguarding Policy and the associated Safeguarding procedures gives detailed guidance to all staff on how to respond to a range of safeguarding issues and make appropriate and timely referrals.	
Relevant Changes (if any)	Click here to enter text.	
Equality Relevance Select LOW, MEDIUM or HIGH	Choose an item.	
If the policy is LOW relevance, you MUST state the reasons here.	Click here to enter text.	
Form completed on:	Date: 22/10/2021	
Form completed by:	Name: Cath Creed	Job Title: Named Nurse for Safeguarding Children, Young People and Adults

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted. (use Equality Relevance to assess the impact on each protected characteristic)	Protected Characteristic	Mitigation
	Age ☑ How: Click here to enter text.	This policy will apply to patients under the age of 18, there is a separate policy for safeguarding adult patients
	Disability ☐ How: Click here to enter text.	Click here to enter text.
	Gender reassignment ☐ How: Click here to enter text.	Click here to enter text.
	Marriage & Civil Partnership ☐ How: Click here to enter text.	Click here to enter text.
	Pregnancy or Maternity ☐ How: Click here to enter text.	Click here to enter text.
	Race ☐ How: Click here to enter text.	Click here to enter text.
	Religion or Belief ☐ How: Click here to enter text.	Click here to enter text.
	Sex ☑ How: Click here to enter text.	The associated safeguarding procedures provide staff with the pathway to be followed if they suspect that a female

		patient has undergone or is at risk of undergoing female genital mutilation. This is an illegal process in the UK and immediate action needs to be taken see Section 13 subsection 6
	Sexual Orientation ☐ How: Click here to enter text.	Click here to enter text.
	Human Rights (FREDA principles) ☑ How: Click here to enter text.	This policy will apply the FREDA principles, Fairness, Respect, Equality, Dignity and Autonomy, and is related to all patients under the age of 18, including those patients with disability and may also lack mental capacity. FREDA principle 1: All patients will be treated fairly, having the same access to health care and planning. Plans of care will be designed around the individual needs of each patient using a person centred approach. FREDA principle 2 & 4: All patients will be cared for with respect and dignity. All patients and families will be treated with the highest of respect and given the best possible care, tailored around their health, educational, social, emotional, psychological, physical and cultural needs. FREDA principle 3: Patient and family satisfaction will be monitored, by the Trust which will include identification of compliance with quality and equality standards FREDA principle 5: Patients will be empowered (where they have capacity) and supported to manage their own health care, When appropriate staff will promote self-management and independence and include the patient and their family in discussions and decisions regarding management of their health

Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	No gaps have been identified
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See Gunning Principles for public consultation requirements. How has consultation influenced the policy?	Children and families are encouraged to complete the Friends and Families Test Children and Families who attend the Rainbow Centre are asked to participate in an annual Patient Satisfaction Audit
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	This policy will ensure that there is a framework to safeguard all children who access the services of the Trust. This policy will also ensure that staff are aware of their duties and responsibilities in relation to safeguarding all children and accessing training appropriate to their role • Safeguarding Adult Policy and associated procedures • Transition to Adult Services Policy • Mandatory Training Policy • Consent Policy • Records Management Policy
Public Sector Equality Duty Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	a) Eliminate discrimination, harassment, victimisation etc Click here to enter text.
	b) Advance equality of opportunity Click here to enter text.
	c) Foster good relations Click here to enter text.
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐
Monitoring Include details of how the equality impact will be monitored.	Continuous monitoring of the effectiveness of this policy will be undertaken by the safeguarding nursing team who are routinely informed of all safeguarding concerns. Monitoring will also include the auditing of referrals made to social care and Early help Assessments that have been undertaken There will be a quarterly Case Review Audit of 10 patients to ascertain - • Were appropriate internal assessments undertaken • Was information communicated effectively • Were appropriate external / multi agency / specialist assessments undertaken • Were LSCB procedures followed • Was the appropriate documentation completed to the approved standard • Was the voice of the child heard

Review of Equality Analysis (if indicated)	Rationale for review: Click here to enter text.	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If MEDIUM or HIGH relevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Cath Creed	Job title: Named Nurse for Safeguarding Children, Young People and Adults
Approval Committee:	Community Policy and Procedures Sub-Group	Date approved: 03/11/2021
Ratification Committee:	Clinical Quality Steering Group	Date ratified: 09/11/2021
Person to Review Equality Analysis:	Name: Click here to enter text.	Review Date: 09/11/2024
Comments:	Click here to enter text.	

Alder Hey Children's
NHS Foundation Trust

E4 – SUPPORTING SICKNESS AND ATTENDANCE POLICY

Version:	11.3
Name of Ratifying Committee:	Workforce & Organisational Development Committee
Date ratified:	02/03/2020
Name of originator/author:	Zoe Connor (HRBP) Health and Wellbeing Steering Group
Name of approval committee:	Employment Policy Review Group
Date Approved:	11/02/2020
Executive Sponsor:	Director of Human Resources and Organisational Development
Key search words:	Attendance, sickness, absence, E4
Date issued:	April 2024 (Extension)
Review date:	September 2024

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Short Term Absence Flow Chart

Employee notifies Manager, or appropriate individual within department, of their absence prior to start of shift

Employee Returns and **submits medical certification** (available on the intranet & Appendix D) (self-certificate for 7 days or less, or GP certificate for absences of more than 7 days)

Manager to **record** on the MSS ESR system within 7 days

Early Intervention referral to OH to be made for absences related to;

- Stress
- Work related Injury
- Musculoskeletal
- Surgery

If Employee does not notify manager of absence, manager to make contact with individual/ next of kin

On return to work Manager to conduct **Return to Work Interview** within 48 hrs (working days) and update MSS system. During interview absences / triggers to be reviewed and proceed to stage 1 review if appropriate

Stage 1 First Formal Review
Line Manager to arrange meeting and send Invite letter, allowing representation. Manager to summarise meeting in writing and issue copy to individual and to HR for recording purposes.

12 Month Review Period – Have there been any further absences as per triggers in section 9.2 of policy during review period?

Yes

No → Continue to support employee's health and wellbeing and ensure support / adjustments in place, as appropriate

Stage 2 - First Formal Meeting
Line Manager to arrange meeting and send Invite letter, allowing representation. HR Adviser may be present to provide support. Manager to summarise meeting in writing and issue copy to individual and HR for recording purposes (refer to Toolkit)

12 Month Review Period – Have there been any further absences resulting in a trigger in line with section 9.2 of policy during review period?

Yes

No → Please see section 14

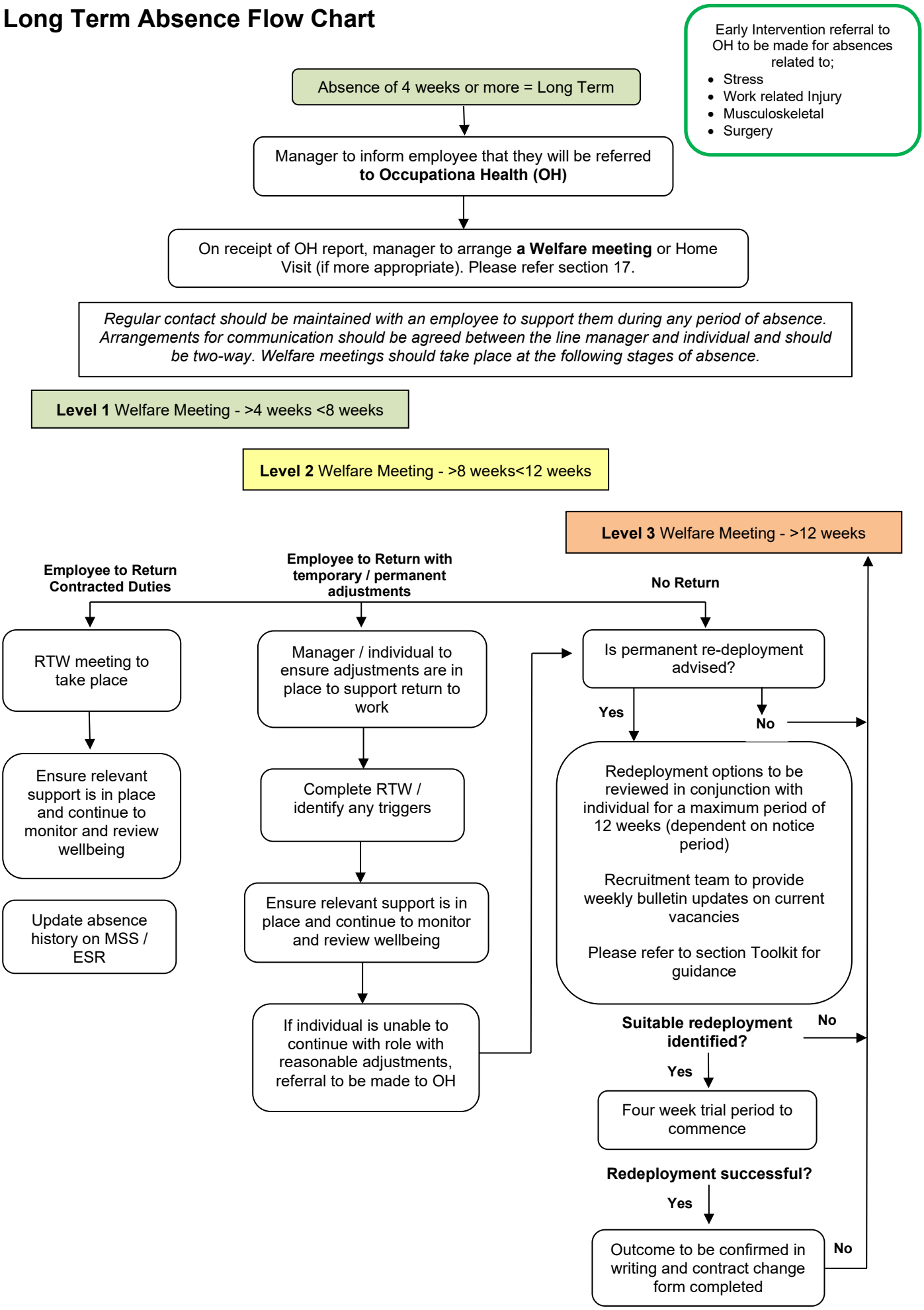
Stage 3 – Final Formal Meeting
Manager to escalate sickness management process to **Divisional Senior Manager.** Final formal review meeting to be arranged with HR present (Section 15). Manager to send invite letter, allowing representation. Previous Line Manager, with support from HR, to provide a summary of support put in place to date with relevant documentation, and copy to be sent to all parties prior to review meeting.

Summary and outcome of meeting to be issued in writing to all parties present, including details of right to appeal if applicable

If dismissal on grounds of Ill Health Capability - line manager to inform payroll

No dismissal - return to Stage 2

Long Term Absence Flow Chart



Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
11.3	April 2024	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Current	Extension given until September by Staff Side to enable approval and review
11.2	August 2023	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Archived	Extension
11.1	February 2023	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Archived	Extension
11	March 2020	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Archived	
E4 - Sickness Absence & Management of Attendance Policy				
10.3	October 2019	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	Interim extension
10.2	April 2019	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	Interim extension
10.1	January 2017	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	
10	April 2016	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	
E4 – Promoting and Supporting Attendance at Work Policy				
9	April 2014	Taffy Chisango, HR Adviser	Archived	Employment Policy Review Group
E4 - Sickness and Attendance Management Policy				
8	December 2013	J Brannon - HR Manager, M Mander - CSP Rep, James Quinn -UNISON Rep; M Salcedo - HR Manager	Archived	Policy updated including management reference guide
E4 - Sickness Absence Policy				
7	February 2012	Jackie Waring	Archived	New Occupational Health Referral Form Appendix C
6	June 2010	Linda Guatella	Archived	Policy updated to include the new medical statement and a new Occupational Health Referral Form Appendix C
5	May 2009	Linda Guatella	Archived	
4	October 2006	Greg Thompson	Archived	
3	August 2006	Hannah Ainsworth	Archived	
2	August 2005	Greg Thompson	Archived	
1	August	Jayne Shaw	Archived	

	2003			
0	March 1995	Unknown	Archived	

Record of changes made to Supporting Sickness and Attendance Policy – Version 11.2			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	6 month extension

Record of changes made to Supporting Sickness and Attendance Policy – Version 11.1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	6 month extension

Record of changes made to Supporting Sickness and Attendance Policy – Version 11			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Various	Various	Title updated. Further reference and information on reasonable adjustments. Signposting and support included on IVF / Gender Reassignment / Menopause etc. Clarity on sickness stages for short term sickness. Clarity of reasonable adjustments and manager discretion for managing absences. Clarity on Equality Act and managing long term conditions.	Updated throughout

Contents

1 Introduction

1.1 The Trust is committed to creating an environment which supports employee's health and wellbeing and to promoting good attendance at work.

1.2 The Trust regards its employees as their key asset in providing the best health care to patients and regular attendance at work is vital in assisting the Trust to deliver the highest possible standard of patient care.

1.3 This policy is aimed at supporting an employee's wellbeing, to promote a culture of attendance amongst employees, and to provide managers with a clear framework on how to consistently and fairly support and manage absence.

1.4 This policy aims to ensure that employees are treated according to their personal circumstances and need.

1.5 This policy applies to all employees of the Trust, including those employed on fixed term and honorary contracts

1.6 This policy covers:

- The responsibilities of those involved in attendance management
- The procedure for the management of short-term sickness absence
- The procedure for the management of long term sickness absence

2 Health and Wellbeing

2.1 The Trust is committed to providing individuals with the support and guidance to promote their wellbeing in work

2.2 Health and wellbeing incorporates a number of factors, which include physical, psychological, social, economic and environmental factors. If any of these are out of balance, then this can have a negative impact on wellbeing.

2.3 As part of the Trust's Health and Wellbeing offering, there are a number of benefits and supporting activities including fast track physiotherapy, physical activities, counselling, holistic therapies, chiropody, signposting and guidance and Health and Wellbeing services provided by Team Prevent (**www.teampreventwellbeing.co.uk)**. The pin code needed to register is 2007.

3 Definitions

3.1 A list of definitions can be found in Appendix A.

4 Sick Pay

4.1 The scales on NHS sick pay allowance are outlined in Section 14 of the NHS Agenda for Change Terms and Conditions.

4.2 There may be instances where Sick Pay is to be withheld, in cases where employees have not issued timely medical certification or a back dated medical certificate, and the period of absence is considered unauthorised. Repeat occurrences may result in formal action under the Trust's Disciplinary policy as a potential breach of the employee's responsibility within this policy.

4.3 Whilst in receipt of sick pay during a period of sickness absence, employees are not permitted to undertake paid employment (in the NHS or external) without written consent from Divisional Senior management. In circumstances where it is requested

4.4

4.5

4.6

4.7

4.8 to undertake work elsewhere, the line manager should escalate to Divisional Associate Chief Operating Officer or Nurse who, in line with HR advice, confirm in writing if this is agreed.

5 Duties & Responsibilities

5.1 A list of individual and departmental duties can be found within Appendix B of this policy.

6 Occupational Health (OH)

6.1 Occupational Health provides expert advice and guidance to managers and the Trust on the needs of an individual, and identifies a range of resources and options available to support and maintain health and wellbeing.

6.2 In addition to the medical care provided by their dentist, GP or other health professionals, an employee may be required to attend an assessment with Occupational Health when asked to do so.

6.3 Management can make an Occupational Health referral by registering for the portal on the Alder Hey intranet and then accessing the portal: https://eopas.teamprevent.co.uk/GenohsisPortal/Genohsis_Portal.aspx

6.4 In all cases, it is advised that before an employee can be referred by their line manager to Occupational Health, the referral must be discussed with the employee, where possible.

6.5 A referral to Occupational Health can be done at any stage; however an Early Intervention referral should always be undertaken without delay in the following circumstances:

- Immediately where the absence relates to *musculoskeletal problems*, *stress at work* and *any planned surgery*.
- Before any stage of the Short Term Sickness Procedure and after 4 weeks absence in line with the Long Term Sickness Procedure, unless absence relates to one of the three reasons as detailed above, where an immediate referral must be completed.

6.6 An employee can self-refer to Occupational Health at any time. At the time of the consultation it will discussed if it felt to be appropriate for a report to shared with their manager and whether they give their consent for this.

6.7 Employees who fail to attend Occupational Health, or fail to notify both their manger and Occupational Health within 48 hours that they are unable to attend, the cost of the missed appointment will be subject to a charge.

6.8 In situations where there is conflicting advice from Occupational Health and from an employee's GP or specialist, the Trust will normally be guided by the advice of Occupational Health.

7 Notification of Sickness Absence

7.1 On the first day an employee is unable to attend work due to sickness, it is their responsibility to report their sickness absence by telephone (or by text phone for employees with a hearing impairment) to their manager or designated deputy (as per their local procedure), as soon as they become aware that they will not be able to attend work. Early notification is particularly important when alternative cover needs to be arranged. This will normally be no later than the normal time of commencement of duty and within first hour, wherever practical.

8 Pregnancy / Maternity Related Absences

8.1 Where absences are related to pregnancy, individuals should be supported in line with this policy to facilitate a return to work as soon as possible, with any necessary support or adjustment to duties during the pregnancy. However any absences will not be factored into short term triggers of this policy. In addition, referral to Occupational Health may be required for advice and support.

8.2 If an employee is off sick due to pregnancy related illness on or after the fourth week before the expected week of confinement, their ordinary maternity leave will commence the day after their first completed day of sickness absence. For further information, also see Trust's Maternity, Paternity and Adoption leave Policy - E22).

8.3 Where a pregnant employee suffers from non-pregnancy related sickness absence, these absences will count towards the management of sickness absence as usual.

9 Planned Absence for Surgery or Ongoing Treatment

9.1 Sickness absence can be planned where it is known that the employee will be undertaking a programme of clinical treatment that will mean they are absent from work for a recognised period of time. As an organisation, the Trust will ensure that all staff undergoing planned or ongoing treatment are supported and provided with reasonable adjustments.

9.2 Where an employee provides notice of surgery or ongoing treatment, Line Managers will make a referral to Occupational Health immediately, via Early Intervention, prior to the employee's surgery. This will provide an opportunity for the employee to discuss any concerns and to seek advice on adjustments to their job, which may be incorporated into their return to work plan.

9.3 The manager and employee will meet prior to the absence and discuss the following:

- The likely period of time the employee will be absent;
- Agreed dates and times for maintaining regular contact, to update each other on work and progress of recovery;
- Agreed date and time for a formal meeting to start to plan a return to work;
- Any other issue of concern for either party;
- A mutually agreed plan must be drawn up and a copy kept by both parties;
- Support in the drawing up this plan can be obtained from the Occupational Health Department.

9.4 In cases of gender reassignment surgery, the manager should discuss with the member of staff how best to support them with this process and the basis of a return to work. Occupational health and professional medical advice should be sought to ensure that individuals have the relevant support and adjustments in place. To support and facilitate appointments, sick leave will be utilised as appropriate, and mixtures of annual leave and unpaid leave also utilised. An employee would not be progressed through the short term policy due to absences connected with this treatment.

9.5 In cases of In Vitro Fertilisation (IVF), the manager should discuss with the member of staff how best to support them. This will be individual to the member of staff and will be dependent on personal circumstances. Occupational health and professional medical advice should be sought to ensure that individuals have the relevant support and adjustments in place. To support and facilitate appointments, sick leave will be utilised, as appropriate, and mixtures of annual leave and unpaid leave also utilised. An employee would not be progressed through the short term policy due to absences connected with this treatment.

10 Cosmetic Surgery

10.1 Unless for a medical reason confirmed in a medical report, any absence taken for the purposes of cosmetic surgery cannot be taken as sickness absence and should be covered by annual or unpaid leave (if agreed by the manager). This time off must be agreed in advance with the line manager.

11 Supporting Women's Health

11.1 It is advised that managers undertake informal conversations with staff which will enable discussions if there are any changes in health, including symptoms relating to the menopause. It may be valuable simply to acknowledge that this is a normal stage of life and that adjustments can easily be made. Such conversations can identify support at work that can help women remain fully productive and encourage them to discuss any relevant health concerns with their GP and occupational health. Further support can be found here.

12 Returning to Work

12.1 The return to work meeting is an important element in the management of sickness absence and it is important that it is undertaken consistently and appropriately after every period of absence.

12.2 Return to work (RTW) meetings are required to be carried out by a manager following any period of sickness absence (whether short or long term – i.e. more than 4 weeks) no later than 48 hours of the employees return, or as soon as practicably possible. (RTW form can be found the management toolkit).

12.3 The return to work meeting should be a supportive meeting. It should be carried out in a sensitive and considerate manner, where the primary focus is ensuring that the employee is fit and well to carry out their duties required.

12.4 Return to work meetings should:

- be conducted in private, with sensitivity where any issues can be explored in a caring and concerned manner

- be approached with an open mind, and give the employee the opportunity to discuss reason behind their absence
- not be judgmental, and assumptions about the absence should not be made
- an opportunity to discuss any occupational health advise and identify adjustments that may be supportive
- an opportunity for signposting to relevant support services
- an opportunity to discuss absence history and consider whether any formal review meetings are required

12.5 Management are required to enter the date of the return to work meeting on the MSS ESR system within 7 days following the employee return and retain copies of those discussions securely in their local personnel file. Guidelines and a template of return to work forms can be found in the Toolkit.

12.6 Overtime and bank work will not be permitted, either within the organisation or elsewhere until an employee has resumed their agreed contractual hours with ongoing review where deemed necessary. Mangers also have the discretion to withhold any overtime or bank work, if appropriate, and will need to notify NHSP of any such restrictions.

13 Reasonable Adjustments

13.1 Employers have a duty to make reasonable adjustments to ensure workers with disabilities, or physical or mental health impairments, are not disadvantaged when doing their jobs and formal risk assessments may be required to support an employee in work.

13.2 In many cases, simple and cost-effective workplace adjustments can make a big difference and enable people with health conditions and disabilities to remain in work. The adjustment needed could be a change in practice or workload.

13.3 The aim of the adjustment is to minimise or reduce the impact of the health condition for the employee and enable them to carry out their job / duties.

14 Sickness Absence Triggers

- 3 episodes of absence in a 12 months rolling period and/or
- 10 days or more absence in a 12 month rolling period (pro rata for part time staff see Appendix E) and/or
- Any trend or pattern of absence causing concern.

Staff who work long days or longer than the standard hours (i.e. 7.5) in the day will have triggers based on hours recorded as sick, rather than days. See Appendix E for chart / formula to calculate.

14.1 It is important to be able to distinguish, and act appropriately, between both short term and long term absences and to deal with them separately as set out in the policy. Nevertheless, there can be occasions where the pattern of absence of an individual staff member is both short term and long term, and in these instances both elements of the procedure may be involved.

14.2 Where an employee gives the reason for absence as an underlying health issue that could amount to a disability under the Equality Act 2010, the manager must refer the employee to the occupational health department. This includes where the employee states that they are suffering from stress.

15 Short Term Absence - The Procedure

15.1 A brief overview of the short term sickness procedure is shown in a flow chart at the start of this policy.

15.2 For sickness absence as a result of bereavement, long term or chronic medical conditions or ongoing medical treatment which could amount to a disability under the Equality Act 2010, managers should be aware of the organisations responsibility to make reasonable adjustments. It should be considered when the absence is wholly or partly for a disability-related or long term reason, that the trigger points referred to in this policy are appropriately modified to take this into account. Other adjustments and modifications to the procedures set out in this policy may also need to be made and should be considered as part of welfare and return to work conversations. Advice should be sought from Human Resources department and Occupational Health, as appropriate.

15.3 Management are required to submit to staff all invite letters and outcome letters (templates can be found in the management toolkit) for each formal stage of the policy. The employee has the right to be accompanied by a trade union representative or work colleague in all the formal stage meetings**.**

Formal Stage 1: First Formal Review

a) Where staff have triggered as a result of sickness absence (section 14) the line manager may be required to arrange a Formal Stage 1: First Welfare Review Meeting. The aim of this meeting is to identify any support the employee may require in order to improve their attendance. Invites to this meeting should be done in writing at least 5 days prior to the proposed meeting date. At this meeting a potential outcome may be confirming that the employee will be at Formal Stage 1 of the procedure with a review period of 12 months from the date of the meeting.

b) Further Managers Guidance can be located in the management toolkit. It is not necessary, unless in exceptional circumstances, that HR be present at this meeting.

c) An Occupational Health referral should be discussed and, if deemed necessary, should be completed before the meeting to clarify any support, identification of the basis of the employee's sickness absence and any underlying conditions.

d) If during the 12 month review period, the employee either has no further absence or if the absence is less than the trigger points (see section 14), the employee will be automatically be removed from Formal Stage 1. If the employee has future episodes of absence after being taken off the stage, their overall absence rate will be considered over the last 12 months, and if the triggers are met, the employee may be invited to attend a further Formal Stage 1: First Formal Review.

e) At any time within the 12 month review period, if the staff member has sickness absence at the level of the triggers as detailed in section 9.2, the manager should review the sickness absence to date, the circumstances of the sickness absence,

the needs of the individual and the support in place. If appropriate, the manager should proceed to Formal Stage 2 – First Formal Meeting.

Formal Stage 2: First Formal Meeting

a) In the event of further / repeat absences during the 12 month review period, as outlined in the triggers in section 14, it may be necessary to convene a Stage 2 Final Formal Meeting. Consideration should be given to the reasons for further sickness absence prior to proceeding, to ensure the necessary support is in place to support an individual's attendance at work.

b) It is recommended that prior to a Formal Stage 2 meeting taking place that an up to date Occupational Health report is obtained to establish any additional support or adjustments.

c) Following a Formal Stage 2 meeting, the manager will send a letter to the individual to confirm the outcome and any agreed actions or next steps. Following this, if there are no further absences during the next 12 month review period, the sickness management process will be ended. If there are absences but they are less than the trigger points (see section 14), then the employee will return to Formal Stage 1 of the policy, with a 12 month review period from the date the Formal Stage 2 ended.

d) For individuals with chronic or long term conditions which may be recognised within the Equality Act (2010), managers are advised to consider the circumstances relating to the episodes of sickness absence and review the support in place for an individual before progressing to the next stage of this Policy. It may be considered a reasonable adjustment to **not** progress an individual to the next stage of Policy, given individual circumstances and needs. Managers should seek advice and guidance from occupational health and a Human Resources representative as appropriate. It may also be beneficial to also seek advice from other relevant specialists.

e) At any time within the 12 month review period, if the staff member has sickness absence at the level of the triggers as detailed in section 14, the manager should review the sickness absence to date, the circumstances of the sickness absence, the needs of the individual and the support in place. If appropriate, the manager should proceed to Formal Stage 3 – Final Welfare Review Meeting.

Stage 3: Final Formal Meeting - Procedure

a) In the event of further / repeat absences during the 12 month review period, as outlined in the triggers in section 14, it may be necessary to convene a Stage 3 Final Formal Meeting. Consideration should be given to the reasons for further sickness absence prior to proceeding, to ensure the necessary support is in place to support an individual's attendance at work.

b) Prior to progressing to a Final Formal Meeting, redeployment options should be given due consideration, and managers should seek advice and guidance on redeployment from Occupational Health and a HR Representative as appropriate. Further guidance can be found in the toolkit.

c) If it is considered appropriate to progress to a Final Formal meeting, the manager responsible for managing and supporting the welfare and sickness absence of the member of staff will be required to compile a summary of the sickness absence

and support in place, with all accompanying documentation, to demonstrate the support offered and adjustments in place.

d) The Final Formal Meeting will be chaired by a Trust senior manager, in line with the Scheme of Delegation as detailed in the Trust's Disciplinary Policy - E5, and should be supported by a Senior Human Resources Representative. The individual can be accompanied by either a Trade Union representative or workplace colleague.

e) The manager supporting the member of staff will provide a summary of the support and adjustments in place to date. The meeting will provide the opportunity to review absence history to date, the support in place and the options available moving forward.

f) A manager must have an up to date report from Occupational Health prior to this meeting being arranged, to ensure medical advice is taken into account when considering the potential outcomes, including termination of contract employment due to Ill Health Capability.

g) There are two potential outcomes of the Stage 3 meeting:-

- Termination of the employee's contract of employment due to Ill Health Capability
- Further support and adjustments- the employee will be placed back on Stage 2 for a further review period of 12 months.

h) The meeting Chair should inform the employee verbally of the outcome of the meeting on the day of the hearing. In exceptional circumstances, the outcome should be in writing no later than 5 working days after the date of the meeting. If the decision is to terminate their contract of employment, the employee should also be advised of details of their entitlements, such as the right of appeal, and this should be confirmed in writing.

i) Further advice should be taken with the Human Resources Department regarding whether it is appropriate to contact the relevant Regulatory Professional Body (where applicable).

16 Long Term Sickness Absence

16.1 The triggers defined under long term absence are referred to as levels. They commence where employee's absence is for four weeks or more (or known at an earlier stage to be more than 4 weeks)

16.2 Long term sickness absence should be treated separately to the short term triggers. Levels are to provide guidance only on a time frame for support, where this is medically appropriate to do so. In some situations, it may be necessary to proceed straight to a Final Welfare Meeting if there is no immediate or foreseeable return to duties of the same nature or adjusted basis (including re-deployment), which has been confirmed through medical advice and guidance. In such instances, management are required to contact a representative from the Human Resources Department.

- Level 1: Welfare Review (> 4 Weeks < 8 Weeks)
- Level 2: Welfare Review (>8 Weeks < 12 Weeks)
- Level 3: Final Review (>12 Weeks), including referral to Final Review Meeting

17 Long Term Sickness Absence Procedure

17.1 This type of sickness absence relates to episodes of four weeks or more.

17.2 The Long Term Sickness Absence Flow Chart is on page 3.

17.3 The manager should look at options and practical ways to support absent employees to return to work, giving due consideration to both the wellbeing of the employee and the requirements of the role, to ensure the necessary support and adjustments are in place.

17.4 Employees absent due to long term sickness, will need help and support during their recovery and their return to work. An understanding and sensitive approach should be taken by the manager in all cases.

17.5 Managers should at the earliest opportunity proactively and positively manage long term sickness, with the primary aim of supporting the employee and facilitating a return to work as soon as possible.

17.6 Following four weeks of absence (or immediately on awareness that the absence is to extend beyond 4 weeks), the manager should refer the employee to Occupational Health, if they have not already done so.

17.7 The manager will arrange to meet with the employee after the fourth week of absence (ideally when the Occupational Health outcome is available) and then on a regular basis thereafter. The frequency and format of these regular catch-ups will be dependent on the nature of the absence, and should be agreed with the employee. Arrangements for such contact should be agreed when the sickness is first reported and kept under review. The employee will have the right to be accompanied by their staff side representative or work colleague, and it may be appropriate for a representative from HR Department to also be attendance. The employee will receive a record of the meeting in writing.

17.8 The employee must keep in contact with their manager on a regular basis throughout their absence, and update on any developments and availability for review meetings and catch-ups. This contact allows the manager to keep track of the employee's recovery and progress in order to facilitate return to work, when appropriate

17.9 The purpose of the meetings is to support the employee and explore any support and adjustments they may require to facilitate a return to work. At these meetings the following issues may be considered;

- Occupational Health advice and any other medical advice available.
- Potential return to work and any adjustments that may be required, either temporary or permanent, and if this should be on a phased basis, as advised by Occupational Health, particularly where the employee has a disability as defined by the Equality Act (2010). Potential for re-deployment if advised by Occupational Health.
- Any re-training, mentorship or additional support needed.
- Redeployment - temporary or permanent
- Ill Health Retirement, if applicable.

17.10 If the employee is unable to return to their current post, as advised by Occupational Health, and no suitable alternative employment can be found within a reasonable

timeframe, a Final Review Meeting will be undertaken where termination of the employee's contract of employment due to Ill Health Capability will be considered, as one option. The manager responsible for managing and supporting the welfare and sickness absence of the member of staff will be required to compile a summary of the sickness absence to date, support in place and the options explored to facilitate a return to work, with accompanying documentation to demonstrate the support offered and adjustments in place

17.11 This meeting will be chaired by a senior manager, in line with the Scheme of Delegation as detailed in the Trust's Disciplinary Policy. The panel chair must have a recent report from occupational health prior to this meeting being arranged, to ensure medical advice is taken into account when considering the options available.

17.12 Sick Pay entitlement does not have to be exhausted before a Final Review can be considered.

18 Postponement of Formal Meeting for the Purpose of Securing Representation

18.1 It must be recognised that in cases of long term ill health in particular, there will be occasions when the employee may be too unwell to attend a proposed meeting. Any such request for postponement will therefore be dealt with sympathetically based on the individual circumstances.

18.2 Employees are responsible for identifying their Trade Union representation. Where an employee requests the postponement of a formal sickness meeting due to difficulties in organising representation, the employee or his representative must suggest an alternative time within 5 working days of the original meeting. Where the request is judged to be unreasonable, the manager may, in conjunction with HR, decide to proceed with the meeting as arranged and, if necessary, in the absence of the employee.

19 Annual Leave & Sickness Absence

19.1 The use of annual leave / lieu days to cover periods of sickness is not permitted but can be used to facilitate a return to work. This may follow a phased return to work in agreement with the Manager.

19.2 For sickness absence as a result of bereavement, long term or chronic medical conditions or ongoing medical treatment, managers should give due consideration, based on individual circumstances, to the use of annual leave to facilitate the attendance at appointments.

19.3 If an employee is on long term sickness they may wish to take a holiday to facilitate their recovery. This must be discussed and agreed with their line manager before any holiday is taken, as they will not be available for meetings during that time.

19.4 Any annual leave taken during a period of sickness will continue to be recorded as sickness absence on ESR. The sickness absence episode **should not** be ended. Annual leave taken will be deducted from an individual's annual leave entitlement but will not be recorded on ESR. Managers are required to keep an offline record in these circumstances. If the employee has gone onto half or no pay, a manager should request payment to be made in lieu via an ETAD.

19.5 To comply with the European Working Time Regulations[1] sickness absence that bridges two annual leave years, or where there is insufficient time for the leave to be taken during the leave year, the employee is entitled to either;

- Carry over the shortfall, for a retrospective period of no more than eighteen months from initial date of sickness
- Be paid as part of final salary payment from the Trust if not resuming for a retrospective period of no more than 18 months

19.6 For the purpose of calculating carryover of annual leave as a result of sickness absence, employees annual leave entitlement is a capped at a maximum of 20 days per annual leave year less any holidays already taken within a maximum 18 month retrospective period from initial start date of sickness. The calculation will be pro-rata'd for staff employed on a part time basis.

20 Conduct while on Sick Leave

20.1 It is expected that the employee will do their utmost to facilitate a speedy return to fitness and to work. The Trust would not normally expect anyone who is absent from work due to sickness or injury to:

- Participate in any sports, hobbies, social or other activities which are in any way inconsistent with their illness or injuries, or which could aggravate the illness or injury or delay recovery.
- Undertake any other employment, whether paid or unpaid, when off sick and claiming Occupational Sick Pay.
- Engage in any activity, which is inconsistent with the nature of the illness or injuries.
- Engage in any activity which is unlikely to be conducive to their recovery.

20.2 A breach of any of the above may be deemed as gross misconduct and subject to the Trust Disciplinary Policy.

20.3 If fraudulent activity is suspected, for example working elsewhere whilst in receipt of sick pay or falsification of sickness absence documentation, the Trust's Local Counter Fraud Department must be notified. In the first instance, managers who have such a concern should contact Human Resources Department. All information provided via any of these reporting lines will be treated in strictest confidence and may be provided completely anonymously. The Trust's 'Raising Concerns at Work' policy will be enforced to ensure that no employee should suffer as a result of reporting reasonably held suspicions.

21 Compensation / Damages

21.1 If an employee is absent as a result of a non-work related accident and receives damages from a third party, they will not be entitled to Sick Pay. If Sick Pay has been paid and damages are received, the employee will be expected to repay the Sick Pay to the Trust.

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[1] http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/EWTD/Pages/EWTD.aspx;

21.2 Contractual sick pay is not normally payable for an absence caused by an accident due to active participation in sport as a profession, or where contributable negligence is proved, unless the Trust agrees otherwise.

22 Planning and Facilitating Return to Work Plans

22.1 When injury or ill health necessitates a lengthy period of sickness absence a phased return to work may support an individual to return back into the workplace. A phased return to work is, by definition, intended to be short term and will gradually increase to normal duties / hours over an agreed period, based on occupational health advice, and not normally exceeding a period of four weeks, or in exceptional cases to a maximum of 6 weeks.

22.2 Employees will be paid at their full contractual pay during an agreed period of phased return, up to 4 weeks, including any contractual enhancements. If an extended phased return is required for a period of longer than four weeks, the manager and the individual should discuss options for facilitating this including annual leave, temporary or permanent flexible working options.

22.3 If the employee's fitness does not enable them to return to their full duties, and reasonable adjustment/s that aim support and facilitate the member of staff to undertake their role cannot be accommodated, or are unsuccessful, then other options may need to be considered, such as ill health retirement. Advice should be sought from Occupational Health, Equality & Diversity Manager and HR.

22.4 If, despite all efforts, the phased return is unsuccessful, a further period of absence may be required. A referral to Occupational Health should be considered with a view to obtaining further guidance on the likelihood of a successful return in future, with or without reasonable / tailored adjustments and / or consideration to permanent or temporary redeployment.

23 Redeployment - Temporary and Permanent

23.1 Temporary redeployment -

If the employee is fit to attend work but not to their substantive post, or a phased return is attempted but is not successful, the manager may also consider temporary redeployment to facilitate a return to work for up to a period of up to 3 months. If redeployment is to a lower banded post, the individual will not suffer a detriment in pay.

23.2 Permanent redeployment -

In circumstances were an individual cannot return to the substantive position with reasonable adjustments and support within the foreseeable future, permanent redeployment should be considered in line with Occupational Health guidance. Individuals will be placed on the redeployment register for a period of up to 12 weeks, dependent on notice period. Further guidance can be found here.

24 NHS Ill Health Pension

24.1 An employee, who is a member of the NHS Pension Scheme, may indicate his/her wish to retire on the grounds of ill health. In order to qualify the employee will need to have been paying into the NHS pension scheme for at least two years. Although individuals have the right to make an application of their own volition, it is normally expected that any application for ill health retirement would need the support of Occupational Health.

24.2 The necessary forms will be initiated by Human Resources Department and after completion by Occupational Health and the employee, the application forms will be sent to the NHS Pensions Agency for a decision. This action will be taken in parallel with consideration of a Formal Review (Level 3) by the Trust on the grounds of ill health, and will not be dependent upon the outcome of a decision by the Pensions Agency. The decision to award ill health retirement benefits lies solely with the NHS Pensions Agency.

24.3 Further information on NHS Pension Scheme can be found on the website.[2]

25 Terminal Illness

25.1 There may be circumstances were a member of staff's health may deteriorate or they cannot be cured or adequately treated, and the possibility that the member of staff has limited life expectancy.

25.2 It may be appropriate in these circumstances for communication to be with a family member or next of kin. Managers are advised to seek advice, guidance and support from the HR department in these circumstances.

25.3 In these circumstances an employee who is a member of the NHS Pension scheme, who is terminally ill with limited life expectancy, may be eligible for adjusted benefits under the Pension scheme. Further information and advice can be obtained from the NHS pension's website.

25.4 Terminal illness of a member of staff can have an impact on the manager, the friends and colleagues. Support is available through the HR team and Occupational Psychology. Further information can be found on the intranet, or through the HR team.

26 Termination of Contract

26.1 Managers authorised to terminate employment under this procedure will be those set out in the Trust's Levels of Authority section, contained within Appendix E of the Disciplinary Policy and Procedure - E5, where the outcome of action taken in accordance with this procedure is termination of employment with notice. There is no entitlement to exhaust contractual sick pay before termination of employment. The Trust may terminate the contract and make payment of notice in lieu, plus any other outstanding payments.

27 Appeal Process

27.1 Employees who are dismissed on the grounds of their capability due to ill health or due to poor attendance are entitled to appeal to the Director of Human Resources and Organisational Development within 10 working days from the date of the letter confirming the outcome, stating details of the reasons for their appeal. In summary the individual will have the opportunity to present their case for appeal to an Executive Panel consisting of Executive and non-Executive Directors. The outcome of the Appeal Panel is final and exhausts all internal appeal processes.

28 Monitoring

28.1 Monitoring will include monthly HR dashboard reporting contained within Board and Corporate reporting processes. This includes equality monitoring.

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[2] http://www.nhsbsa.nhs.uk/Pensions.aspx;

28.2 The Trust will evaluate this data on an on-going basis to ensure that it continues to meet its legal obligations under The Equality Act 2010[2], and to assist in developing policies, processes and procedures that take a pro-active and supportive approach to disabled employees and potential employees.

29 Further Information

Equality Analysis (hyperlink)

References

- Data Protection Act 1998
- Disability Discrimination Act 2005
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
- The Equality Act 2010

Associated Documentation

http://www.dwp.gov.uk/docs/fitnote-employer-guide.pdf

This policy should be read in conjunction with the following HR policies:

- Management Toolkit
- Flexible Working Policy
- Special Leave Policy
- Flexible Retirement Policy
- Stress Policy
- Drug and Alcohol Policy
- Capability and Performance Policy
- Disciplinary Procedure
- Grievance Procedure
- Infection Control Policy

Appendix A - Definitions

i. Management Toolkit – This policy works in conjunction with a management toolkit provided by Human Resources and available on the Intranet. The toolkit provides guidelines, template letters and examples to assist managers in the day to day management of sickness absence.

ii. Return to Work Interview (RTW) – Supportive interview between management and staff following any absence due to sickness completing a form and identifying if any, support and/or temp adjustments.

iii. Electronic Staff Record – (ESR) refers to the NHS HR and payroll system which is used by managers in entering timely information relating to any employee's absence.

iv. Manager's Self-Serve (MSS) – refers to management entry when recording sickness absence onto the ESR systems.

v. Statement of Fitness to Work ("Fit Note") - This is normally provided by the employee's medical practitioner (e.g. GP) as evidence of why they cannot work due to an illness or injury after the 7th day of sickness. The employee's doctor can also advise that they 'may be fit for work' or provide information on functional effects of the condition and/or any treatment planned and possible adjustments which could be made to aid a return to work.

vi. The Equality Act 2010 (2010) – A person with a disability for the purposes of the Act is if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. i.e. a substantial and/or long-term adverse effect on the employee's ability to carry out normal day-to-day activities'

'Long-term' means that the impairment must last, or be likely to last, for more than 12 months, or which is likely to last for the rest of the life of the person affected.

vii. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Act 1995.

viii. ELFS- East Lancashire Finance Services, Alder Hey's Payroll & Pension Provider.

ix. UA - unauthorised absence - occurs when an absence is not supported by current self-certification, medical fit note or by prior approval of your manager.

x. E.I – Early Intervention - This is a supportive and preventative Health and Wellbeing approach for Employees to enable Early Access and Intervention to evidence based professional advice, support and treatment (if required) relating to their health, their role and the workplace.

Appendix B - Individual Duties & Responsibilities

Line Manager Responsibilities;

i. Promote a positive attendance culture in the workplace through effective people management and promotion of health and wellbeing.

ii. Ensure all employees, including new employees during local induction, are aware of and understand this policy and the absence reporting procedure.

iii. Maintain appropriate contact with the employee during periods of absence(s), facilitate their return to work and adhere to **all** elements of the policy in ensuring that their employees are fully supported with reasonable adjustments in place

iv. Seek advice from Occupational Health in line with timeframes outlined in this policy and take steps to implement specified recommendations where reasonable.

v. Liaise and seek advice from Human Resources prior to taking each formal stage of the process including when managers may have to act outside of the provisions of this policy and procedure.

vi. Take direct responsibility for managing attendance consistently in line with this policy and providing appropriate and reasonable support and adjustments to staff

vii. Conduct return to work interviews with employees after **all** period of sickness absence and within 48 hours of an employee's return to work, ensuring they are fit to return. Identify any work related issues which can be addressed and implement support and adjustments where appropriate.

viii. Enter accurate sickness absence information onto manager self-service of ESR system in an accurate and timely manner

ix. Repeated failure to implement the policy, undertake return to work interviews and provide reasonable support and adjustments may result in formal action in line with Trust policy and procedures

x. Give appropriate consideration to the personal circumstances of employees who are absent for reasons relating to long term conditions, disability, pregnancy or work related injury when applying the policy and procedure.

xi. Signpost staff to the Access to Work scheme if they require reasonable adjustments to be made as a result of their disability or long term condition https://www.gov.uk/access-to-work (refer to management toolkit).

xii. Inform the Risk Management Department when an accident at work results in an employee being off sick for more than seven days, so that the Health & Safety Executive can be notified as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

xiii. Retain electronic copies of all RTW's forms, formal letters, risk assessments and OH reports securely for audit purposes and ensure handover file during internal movement in the event of a transfer.

xiv. Review and implement support plans and reasonable adjustments

xv. Should comply with the General Data Protection Regulations (2018) when dealing with sickness absence. All those who have access to personal information relating to sickness absence have a legal responsibility to ensure that this information is treated in

a confidential manner in accordance with the Act. Breaches of confidentiality will be dealt with under the terms of the Trust's Disciplinary Policy and Procedure..

General Managers / Heads of Department responsibilities;

i. Responsible for ensuring that improvements are made within their areas/departments to meet the Trust's sickness absence targets

ii. Ensure management teams report sickness absence and return to work interviews timely and monitor performance as part of divisional performance

iii. To ensure that management teams adhere to the requirements of the Sickness Absence and Management of Attendance Policy.

Human Resources Department responsibilities;

i. To promote the fair and consistent application of the Sickness Absence and Management of Attendance Policy and to monitor the implementation of this policy to ensure procedures are managed fairly across the Trust and compliant with the Equality Act 2010[4].

ii. To support managers and staff and attend welfare meetings as required.

iii. To provide assistance, advice and support to managers and employees in the management of sickness absence and maintaining attendance at work

iv. To collect, analyse and publish departmental and organisational absence statistics

v. To review the continued relevance/appropriateness of policy and procedure on a regular basis.

vi. To provide Divisional Management with sickness absence summary reports highlighting any areas requiring support and focus.

Occupational Health Department responsibilities;

i. Provide line managers with timely and competent medical advice to inform decisions regarding the management of individual cases of sickness absence in order to promote health and wellbeing and support attendance at work.

ii. To promote and advise staff and managers about health and wellbeing in the workplace and the prevention of ill-health.

iii. Inform the line manager and HR of any non-attendance at a booked consultation and of circumstances were records have been closed as a result of non-attendance.

iv. Work with line managers in facilitating an employee's return to full duty as early as possible. This may include providing a medical opinion regarding the risks associated with any rehabilitation plan.

v. Accompany Line Managers at case conferences and advising employees and their managers of the appropriate measures of support, (including rehabilitation, redeployment, advice where disability discrimination legislation may apply and highlighting where medical conditions are reportable under RIDDOR (1995).

Payroll Department responsibilities;

i. ELFS is the Trust's payroll provider. In relation to sickness absence ELFS will:

- Ensure correspondence has been issued to employees in relation to changes to sickness entitlements.
- Send SSP1 to employees
- Inform employees when they are approaching half pay or nil pay.

Staff Side responsibilities;

i. All employees who are members of an accredited Trade Union have the right to be accompanied at all formal meetings by an accredited Trade Union representative. Employees who are not Trade Union members may be accompanied by a workplace colleague.

ii. Staff side representatives must therefore:

- Familiarise themselves with this policy and procedure.
- Advise members in accordance with this policy and procedure.
- Work in partnership with the Trust to promote a culture of health and wellbeing
- Work in partnership with the Trust to ensure policy and procedure is implemented fairly and equitably
- Support effective attendance management across the Trust

Employee responsibilities;

i. Meet the obligations of their contract of employment regarding regular attendance at work and compliance with Trust policies and procedures.

ii. Have an awareness of the impact of ill health on their teams' and service delivery and ensure they are seeking support and managing their health and wellbeing appropriately

iii. Bring any health issues/disabilities to the attention of their manager at the earliest opportunity and make suggestions as to any reasonable adjustments required.

iv. Should be aware, understand and adhere to this policy and procedure**,** which includes reporting any absence from work on the first day to the appropriate manager in accordance with this policy.

v. Maintain regular contact with their manager, advising of their progress and likely return to work date.

vi. Submit the appropriate self-certification and / or continuous medical statements timely and for the duration of the absence.

vii. Participate in return to work interviews after any period of sickness absence

viii. Required to attend arranged appointments to see Occupational Health

ix. Notify both their manager and Occupational Health directly, no later than 48hours prior to an OH appointment in the event they are unable to attend and to rearrange a new date as soon as possible

x. Notify their manager without delay or at the first opportunity in the event they have an accident at work.

xi. Attend regular Welfare Meetings/Sickness Reviews.

xii. If repeatedly unable to attend sickness absence reviews or attend Occupational Health appointments employees may be subject to formal action under the relevant Trust Policy and Procedures. Employees should ensure they are in regular communication with their manger and provide up to date information on their health status and ability to attend meetings so reasonable adjustments can be put into place to facilitate

xiii. Are to refrain from additional shifts (bank, overtime etc.) or unpaid work until a return to work interview has been undertaken and a sustained level of attendance is maintained (post any phased return to work arrangements).

xiv. Should refrain from activities that will delay their return to work

xv. Should refrain from undertaking any activities whilst off sick which are inconsistent with the reason for their absence or may delay their recovery.

xvi. Contact 'Access to Work', where required, and the employee should liaise with their manager to discuss those recommendations.

xvii. Should comply with the General Data Protection Regulations (2018) when dealing with sickness absence. All those who have access to personal information relating to sickness absence have a legal responsibility to ensure that this information is treated in a confidential manner in accordance with the Act. Breaches of confidentiality will be dealt with under the terms of the Trust's Disciplinary Policy and Procedure.

xviii. Only report sickness absence for personal sickness and not for other reasons. The Trust has policies for other types of leave such as Special Leave, Carers Leave and Career break policies. These policies must be used where appropriate. Inappropriate reporting of sickness may result in disciplinary action being taken.

Appendix C - Notification Procedure & Maintaining Contact with Employees

Notification Process:

The Trust's standard notification procedure is as follows:

i. Employees are required to notify their line manager (or alternative nominated person) in line with local department notification procedures by telephone. Failure to contact within local reporting requirement may result in withholding of sick pay for that day. Other forms of communication such a text message should not be used unless in exceptional circumstances or if otherwise agreed

ii. Calls from other people, texts and emails are unacceptable except in very exceptional circumstances as is reporting sickness absence via colleagues. In the exceptional circumstance that the employee is too sick to personally contact their line manager/suitable identified person a close relative or friend may contact the Trust on their behalf.

iii. All employees need to be aware who they should contact in the event that they need to take sick leave. In most circumstances this will be the manager, however, some notification procedures may identify another suitable individual as the point of contact. It is insufficient to simply leave a message with whoever answers the telephone or to leave a text message. In the event that you have been unable to speak directly to your manager to notify them of your sickness absence, your manager (or in their absence a person with designated responsibility) will return your call.

iv. Employees should inform their manager:-
- Of the reason for absence
- Action taken (e.g. GP appointment)
- Of an estimated return to work date and any work commitments which require cover.

v. In the event this is not possible then employees should personally notify the next Senior Manager of their absence.

vi. Where an employee is unable to return to work on their expected date of return they are required to inform their manager/suitable identified person before the start of the working day/shift on which they are expected to resume so that appropriate resources can be put in place to meet the needs of the service.

vii. On returning from sickness the employee should contact their line manager/suitable identified person to inform them when they are returning to work before the next working day/shift starts.

viii. The employee should ensure that during a period of long term sick leave that they maintain regular contact with their line manager/suitable identified person. The reasonableness of the regularity of contact should be discussed by the manager and member of staff and is dependent on service needs and the individual circumstances of the sick leave. If the employee does not initiate and maintain contact, the manager will do so.

ix. Employees should complete a self-certification form on the first day that they return to work up to the first 7 days of absence (Appendix B). This may not be necessary if the employee has obtained a doctor's medical statement that provides cover from the first day of absence.

x. A doctor's statement is required from day 8 to cover the remainder of the duration of sickness absence and must be received by the ward/ department.

xi. Where the employee's absence continues past the expiry date of the medical statement the manager should receive a new medical statement immediately to ensure continuous certificated absence.

xii. Employees whose sickness period includes Saturday, Sunday and bank holiday will automatically be regarded as being sick on these days unless the employee has contacted the ward/department and informed them that they are fit to return to work and where applicable resumed work.

xiii. Employees who do not undertake standard 7.5 hours days will have sickness calculated based on hours of absence during the period concerned

xiv. Failure to comply with the notification procedure where there is not good reason to do so could result in disciplinary action. In addition, the HR Shared Service will be notified of the unauthorised absence which will result in an appropriate deduction in pay for those days absent without authorisation.

Maintaining Contact with Absent Employees

i. Where an employee reports in for work and during their shift falls sick, which results in the employee leaving the workplace, it should not be recorded as sick absence for that day.

ii. Line managers are required to keep a record of all such occasions as stated above, to identify any repeat patterns of absence or misuse of the policy and will recognise the patterns of absence and action as part of the short term triggers, stated within this policy.

Appendix D - Self Certification of Absence

This certificate is to be completed by the employee to cover:-

1. Absences lasting less than 7 calendar days.
2. The first 7 days of any absence lasting 8 or more days (This form must be returned with your Certificate of Fitness).
3. A second certificate must also be completed on return to work.
4. Failure to complete and submit this form to your line manager could result in the loss of sick pay and statutory sick pay and formal action in line with Trust policy and procedure

First Name: Surname

Assignment No: Band: Department:

National Insurance No: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Commencement of Illness		**Time:**
First Working Day of Absence **(if different to the above)**		**Time:**
Last Day of sickness		
Last Working Day of Absence **(if different to the above)**		
Actual Date of Return to Work		**Start Time:**
Total	**Working Days:**	**Working Hours:**

Absence Reason:

Back Condition ☐ Skin Disorders ☐ Other (Mental Health) ☐

Injury/ Fracture ☐ Arms/Shoulders Condition ☐

Headache/Migraine ☐ Stress/Anxiety/Depression ☐

Other musculoskeletal ☐ Cold/Flu ☐ Gastrointestinal problems ☐

Respiratory Condition ☐ ENT ☐ Long term condition ☐

Pregnancy Related Absence ☐ Skin disorders ☐

Benign & malignant tumour/ cancers ☐ Dental/oral ☐ Gynaecological ☐

Other ☐ **Please specify what other**: .

Type of Absence:

Work Injury ☐ Work Related Sickness ☐ Pregnancy Related Absence ☐

Other Sickness ☐ Personal circumstances ☐ Accident Outside of Work ☐

Did this accident cause you to consult a medical practitioner or attend hospital? ☐

Was your injury due to an accident involving a third party, e.g. road traffic accident? ☐

I am signing to confirm that the information that I have provided during my sickness absence is correct to the best of my knowledge and that during this period of sickness absence I have not undertaken any paid or unpaid employment (without prior agreement) whilst also claiming sick pay from the Trust. ☐

or

I have undertaken work during the time I have been absent from work through illness ☐

Please provide details

……

……

Signed: _____ **Print**: **Date**:

NB: *Failure to declare accurate and truthful information on this form may lead to disciplinary action and result in matters being referred to the Trust's Local Counter Fraud Specialist to investigate.*

THIS FORM SHOULD BE COMPLETED WITH YOUR LINE MANAGER AS PART OF THE INFORMAL PROCESS.

NOTE FOR LINE MANAGER

A copy of this page should be placed on the employee's personal file. Where appropriate action is required, an e-mail copy may be forwarded to your relevant HR representative.

Appendix E- Sickness triggers for part time workers

The table below shows in hours those who will trigger following the 10 days in a rolling 12 month as stated in the short term sickness of the policy.

Weekly Working Hours	Trigger Hours (10)	Weekly Working Hours	Trigger Hours (10)	Weekly Working Hours	Trigger Hours (10)
7.5	15	18	36	28.5	57
8	16	18.5	37	29	58
8.5	17	19	38	29.5	59
9	18	19.5	39	30	60
9.5	19	20	40	30.5	61
10	20	20.5	41	31	62
10.5	21	21	42	31.5	63
11	22	21.5	43	32	64
11.5	23	22	44	32.5	65
12	24	22.5	45	33	66
12.5	25	23	46	33.5	67
13	26	23.5	47	34	68
13.5	27	24	48	34.5	69
14	28	24.5	49	35	70
14.5	29	25	50	35.5	71
15	30	25.5	51	36	72
15.5	31	26	52	36.5	73
16	32	26.5	53	37	74
16.5	33	27	54	37.5	75
17	34	27.5	55		
17.5	35	28	56		

Formula: - (Weekly working hours x 2)

Alder Hey Children's
NHS Foundation Trust

M37 – UNIFORM AND DRESS CODE POLICY

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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
9	November 2022	Deputy Director of Nursing	Current	Complete re-write
8	September 2022	Deputy Director of Nursing	Archived	Interim update pending incorporation of feedback from SLT. Further review scheduled to include national uniform audit recommendations
7.3	February 2022	Assistant Director of Nursing	Archived	
7.2	June 2020	Assistant Director of Nursing	Archived	
7.1	September 2019	Assistant Director of Nursing	Archived	
7	August 2019	Assistant Director of Nursing	Archived	
6.2	March 2019	Assistant Director of Nursing	Archived	Extension
6.1	January 2018	Assistant Director of Nursing	Archived	Interim update pending staff survey.
6	April 2016	Lead Nurse, ICS	Archived	
5	October 2012	Lead Nurse, ICS	Archived	
4	November 2008	Risk Manager	Archived	
3	February 2006	Chief Nurse/H&S Adviser/Uniform Policy Group	Archived	
2	March 2003	Unknown	Archived	
1	May 1996	Service Managers / Assistant Director of Nursing	Archived	

Record of changes made to Uniform Policy - Version 9			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Completely re-written	Out of date

Quick Reference Guide – Uniform and Dress Code Policy

Uniform and/or clothing must be smart, safe, and practical and should:

- Take account of staff safety issues
- Provide the wearer with mobility and comfort
- Be durable enough to withstand laundering
- Contribute to identification for both the public and for security services
- Project a professional image to encourage public trust and confidence
- Contribute to the Trust's corporate image
- Designed with a client group in mind reflecting the type of work they undertake

Summary of Policy

This new policy applies to all staff employed by Alder Hey NHS Trust and other persons working within the organisation.

It sets out the uniform and dress code principles for Alder Hey NHS Trust and the expectations for professional appearance for both those whose role requires them to wear a uniform and those staff who are not required to wear a uniform.

It applies equally to those providing direct clinical care and those working in support roles.

The policy considers the expectations of the public in relation to NHS staff's professional appearance.

The policy acknowledges personal and cultural diversity where this does not compromise the safety of patients or employees or damage the professional standing of the individual or the organisation.

It also covers the health and safety and infection prevention and control requirements in relation to staff dress and appearance.

The policy takes account of both the rights of the individual service user as well as the service provider.

Contents

1. Introduction and Purpose

1.1 This policy and procedure sets out the uniform and dress code principles for Alder Hey NHS Trust. This policy has been introduced to protect the safety of patient/service users and employees by ensuring the uniform and appearance at work/dress code of employees complies with infection prevention and control requirements, Health and Safety legislation and to ensure that all employees present a clean, smart professional image. All employees are expected to portray a professional image to patients/service users and members of the public.

1.2 The policy acknowledges personal and cultural diversity where this does not compromise the safety of patients or employees or damage the professional standing of the individual or the organisation. Employees are advised that any proposed deviation from this policy because of cultural, ethnic, religious and physical considerations must be agreed in consultation with the employee's line manager, Infection Prevention and Control, the Human Resources department and Health and Safety.

1.3 Failure to comply with the policy may lead to risks to patients and the employee and, therefore, repeated failure to adhere to the policy may result in disciplinary action being taken in accordance with the Trusts policy.

1.4 The policy describes standards for all employees and specific standards for employees directly involved in the delivery of care. As well as the general standards, there are additional, more stringent requirements for employees providing direct care, who may or may not be required to wear uniform. In order to comply with this policy, all direct care employees must have enough (i.e., sufficient for daily changes) sets of uniform to facilitate good practice in the area of infection prevention and control and health and safety.

2. Scope and Definitions

2.1 This policy will apply to all corporate and non- clinical staff as well as clinical staff directly employed by the Trust, other than when specific conditions may apply. Requests for any variation must be made in writing by the service area manager and sent to the Chief Nurse for approval. The policy also applies to all trainees, students on placement, secondees and staff on honorary contracts or on joint contracts with the Trust and another employee. Where staff are required to wear Personal Protective Equipment, e.g., Estates, the local policy must be adhered to.

2.2 Alder Hey NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and Trust staff. As part of good employment practice, agency workers are also required to abide by the organisations policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work for the organisation.

2.3 It is not the intention of the policy to compel anyone who does not currently wear a uniform to do so. However, all staff, clinical and non- clinical who do not wear uniform are expected to comply with the dress code outlined in the policy.

3. Process / Requirements

3.1 The purpose of the policy is to ensure that all employees are clear on the standard of appearance/dress expected while at work, whether uniform or non-uniform. The appearance at work /dress code details the standards and image which the Trust wishes to convey to all patients/clients, partners and members of the public. This policy outlines the legislation relating to dress code and uniforms within the workplace. This policy will be implemented to ensure that safe practice and a positive identity is adhered to.

3.2 In all cases, the following principles should be supported and promoted, in order to adhere to the recognised legal framework:

- Health, safety, and the well-being of patients / service users
- Health, safety, and the well-being of employees
- Infection prevention and control
  - Public confidence and professional image
- Professional accountability, as defined by professional bodies / councils

3.3 The objectives of this policy are:

- To ensure employees maintain a positive professional image
- To ensure employees wear clothing in line with the principles of this policy
- To ensure that infection prevention and control and health and safety issues are addressed
- To ensure that service users are confident with the policy

4. Infection Prevention and Control

4.1 All employees working in a direct clinical role (regardless of whether they wear a uniform or not) MUST apply the ‘bare below the elbow’ principles whilst delivering care.

- All wrist and hand jewellery must be removed- except one plain ring with no stones or deep engraving
- No false nails, nail varnish or nail adornments
- No long sleeves below the elbow

4.2 When undertaking clinical procedures, long garments (e.g., cardigans) must be removed. Where long sleeved garments cannot be removed (i.e., blouses and shirts), it must be possible for the sleeves to be rolled up to above elbow height, and for them to remain up independently throughout the duration of the procedure. Good hand hygiene is well recognised as the single most effective way to reduce the risk of cross infection; however, contact transfer of bacteria from uniforms leading to transmission of infection has also been recognised.

4.3 The organisation provides uniforms and personal protective clothing to all members of clinical staff. Employees must ensure that they use appropriate PPE (personal protective equipment) as required to reduce the risk of cross infection. Disposable aprons must be changed in – between patients, between episodes of care on one patient or before leaving the clinical area or patient's home in order to adhere to Infection Prevention and Control principles.

4.4 Principles of infection prevention and control apply to all staff regardless of whether they wear a uniform or not. Staff must make sure they are compliant and act in accordance with, the relevant policies in relation infection control and decontamination

5. Dress Code All Staff – General Principles

5.1 Personal Hygiene

5.1.1 All employees should maintain a high level of personal hygiene and be well presented. The chewing of gum is prohibited in all areas. Nicotine gum can be used for the purposes of smoking cessation but never when dealing with patients, carers, or the public (including phone calls).

5.2 Identification Badges

5.2.1 All employees must wear their Trust identification badges at all times in all areas of the organisation for security and identity purposes. Whilst not on duty, when away from Trust premises, the ID badge should be covered or removed for personal safety reasons.

5.2.2 Identification badges will either be clip on badges or lanyards, as appropriate to the member of staff's clinical duties and uniform. Lanyards should be laundered regularly as per IPC guidance, in order to maintain cleanliness. Consideration should be given to any pin badges attached to lanyards and uniforms, in terms of professionalism and patient safety.

5.2.3 Employees who are out in the community with patients should ensure that they have their ID badge on them in the event they are required to formally identify themselves.

5.2.4 The Trust lanyard only must be worn. This provides a level of visible assurance to patients, families, and other staff that the staff member is an employee at Alder Hey. Staff are not permitted to wear alternative lanyards.

5.3 Nails

5.3.1 Staff providing clinical care must not wear nail varnish or nail art whilst on duty. All staff in the clinical area, should ensure fingernails should be kept short and clean in order to comply with our Infection prevention and control and decontamination guidance. The wearing of false/acrylic/gel nails, nail varnish and nail adornments by staff providing clinical care is strictly forbidden as they pose infection prevention and control and health and safety risks.

5.4 Hair

5.4.1 Hair must be clean and well groomed. For staff providing clinical care it must be off the collar and a style that does not require frequent re-adjustment. Keeping hair off the collar reduces the incidence of bacterial growth around the collar areas. Uniformed staff must have their hair tied back if longer than shoulder length. Where hair clips are worn, they must not have the potential to injure employees or patients and must comply with health and safety and infection control standards. The use of hair colourant is an individual choice. Staff should consider patients and families expectations of what constitutes a professional image, if deciding to colour their hair.

5.4.2 Beards must be neatly trimmed unless it reflects a religious belief, in which case it must be kept tidy.

5.5 Jewellery

5.5.1 All employees should ensure that their permitted jewellery is minimal, follows the bare below the elbow principle and does not pose a risk to themselves or others and promotes a professional image. Facial piercing should remain discreet and facial jewellery should be plain and flat. This is to avoid potential harm and also to present a professional image. Any piercings or jewellery which may cause an infection prevention control hazard must therefore be covered or removed. Clinical staff may wear a plain ring (see section 11.1) and one small pair of earrings. Wrist watches must be removed at the start of the working day/shift when giving direct patient care. No necklaces, bracelets or anklets are to be worn. The only exception is a medical alert.

5.6 Make up and Perfume

5.6.1 Make up must be kept to a minimum. The use of strong fragrances should be avoided. Line Managers will use their discretion to discuss with staff members who may be unaware of the strength of their fragrance. Staff in clinical areas should wear no perfume to avoid discomfort to patients and potential allergic reactions. False eyelashes must not be worn by staff working in direct patient contact.

5.7 Tattoos

5.7.1 Where present, tattoos should not be offensive to others and where they may be deemed to be offensive, they should be covered by the individual. It is the responsibility of Line Managers to ensure that dress code complies with health and safety regulations and the Trust Uniform policy. The professional image presented to the public should be a clear consideration when considering the appropriateness of any ‘body art’. New tattoos must be covered with a waterproof dressing provided by the individual until they are healed.

5.8 Footwear

5.8.1 Footwear must be clean and in good repair, suitable for the work task and of a style that is not hazardous to either patient or staff member. For staff working in clinical areas shoes should be soft soled and closed toe. Backless and/or

open toe shoes or sandals and mules/ clogs / shoes of a croc- type style must not be worn for clinical care as these constitute a hazard (Manual Handling Operational Regulations, 1992). Clinical staff who wear uniform should wear black leather or leather type impermeable shoes with a rubber non-slip sole and low heal which give adequate support and are strong enough to prevent damage to toes should anything be dropped on the feet. They should be lace up or slip- on full shoes. Smart trainers (black), that are non-permeable and preferably minus any logos (or with discreet logos) are permitted in appropriate clinical settings. In extreme weather community staff may need to over-ride these requirements for safety reasons (e.g., walking boots in snow).

5.8.2 Footwear is provided by the individual. If alternative footwear is required for medical purposes, the individual will be required to provide medical evidence and be required to have an Occupational Health Assessment.

5.8.3 Shoes for non-clinical staff should be professional and smart. Training shoes must not be worn unless approved by the line manager.

5.9 Cultural and Religious Beliefs

5.9.1 The Trust recognises and values the diversity of its workforce in relation to age, disability, gender, gender reassignment, race/ethnicity, religion and belief and sexual orientation and we respect and uphold the right of individuals to the lawful expression of these differences and will take a sensitive approach when this affects dress and uniform requirements - any member of staff who wishes to wear a particular type of clothing or jewellery for cultural, religious or health reasons should discuss their requirements with their Line Manager. However, there may be circumstances in which there are genuine occupational reasons as to why the wearing of certain articles and/or clothing is not permissible, and priority will be given to health and safety, security, and infection control.

5.9.2 It is recognised that individuals undergoing gender reassignment may require a review of their issued uniform to accommodate for the transition to their new gender. The Trust will show flexibility and, where possible, ensure that provisions are made available for this to take place. If a member of staff needs to vary from the standards set out in this policy, they should discuss this with their manager who will seek appropriate guidance on an individual basis, with advice and support from Occupational Health, Health and Safety Team and Human Resources as required. The trust will endeavour to treat such requests sympathetically, balanced against the needs of the service. All staff must dress in a manner that is sensitive to the social, cultural, diversity and equality needs of other staff, patients, and carers/visitors

5.9.3 Essential Cultural / religious dress will be accommodated as far as reasonably and practicably possible. Individuals who have concerns should discuss them with their line manager in the first instance, who will seek appropriate advice from the Equality & Diversity team.

5.9.4 Modesty sleeves can be worn to protect individual’s rights however clinical need will always be the priority. There is specific guidance for the use of disposable sleeves i.e., when worn to accommodate religious practice or cultural need.

These are utilised in the same way as in the use of disposable gloves, with regard to infection control/H&S requirements

5.9.5 Although the Trust will do whatever is possible to accommodate religious beliefs, in terms of compliance, clinical need and patient safety will always take priority, particularly relating to infection prevention and control.

5.9.6 If a staff member feels that on the grounds of Religious or cultural beliefs, they need consideration regarding the uniform they are required to wear, this must be discussed with their line manager with advice from the Divisional Human Resource Manager.

6. Clinical & Non-Clinical Staff who do not wear Uniform – Dress Code for Work

6.1 Where a uniform is not a requirement of the role, it is important that employees dress in a professional manner. Employees who do not wear a formal uniform must dress in a manner that does not cause offence or embarrassment to patients or others with whom they come into contact.

6.2 Employees who wear their own clothes should ensure that they are suitable for work purposes; clean and in a good state of repair and should look professional at all times.

6.3 Clothing that is unsuitable and must not be worn in the workplace:

- Clothes that are revealing and may cause embarrassment or offence, including but not limited to miniskirts, tops that reveal excessive cleavage or the midriff
- Clothes with logos or advertisements; sports clothing; shorts etc
- Clothes that could be interpreted as intimidating or threatening, (e.g., combat fatigues)
- Ripped or torn clothing
- Denim or leggings/jeggings in clinical areas. (It is recognised there may be some exceptions to this, but this must be agreed by the line manager and be appropriate to the patient/client groups).

6.4 Depending on the job role clothing which covers the face may not be permitted.

6.5 Where an employee or applicant makes a specific request as part of a religious observance the Manager will adhere to the guidance from Human Resources and Occupational Health. Employees must ensure that they follow the principles outlined in Section 4.

7. Clinical Staff who do not wear Uniform – Additional Requirements

7.1 Clinical Staff who wear their own clothes rather than a uniform e.g., some AHP's, doctors; when working in a care/clinical environment should adhere to the general principles of the standards set out above. In particular, they should ensure that their clothes and shoes and permitted jewellery (where appropriate) do not pose a potential hazard to themselves, patients/service users, and other employees from both an infection prevention control and a health and safety

perspective. Employees who wear their own clothes rather than a uniform when working in a clinical environment (which includes patient's home) should also ensure that they portray a professional image that is appropriate to the area of clinical care. Due to the range of clinical care specialties, this will mean that a pragmatic approach to the application of the policy is necessary by the manager. Employees must ensure that they follow the principles outlined in the Quick Reference Guide.

8. Clinical Staff who are required to wear a Uniform

8.1 All employees who are required to wear a uniform must wear the uniform provided and agreed by the Trust. Uniforms will be supplied with the NHS logo. Staff Uniforms provided by an employer which have a permanent NHS Logo stitched to it and can clearly be recognised as a uniform, will mean that the individual will not have to pay tax on the cost of the uniform.

8.2 Employees are required to wash their own uniform as detailed in Laundry Guidance (see section 13).

8.3 For those employees who wear a uniform when working the following must be observed:

- Employees will be provided with an adequate number of uniforms by the Trust.
- The Trust will provide quality clothing that meets infection prevention and control and health and safety requirements and reduces replacement costs.
- All uniform must be clean, ironed, and presentable and employees should have access to a spare uniform in case of accidental contamination by blood, body fluids or any other noxious/toxic substance.
- In the case of gross contamination with body fluids the uniform should be disposed of as contaminated clinical waste.
- Employees must presume some degree of contamination following a shift, even on uniform or clothing which is not visibly soiled. Employees must therefore change out of their uniform promptly at the end of each shift (if changing facilities are available). A clean and freshly laundered uniform must be worn daily.
- Employees must ensure that they follow the principles outlined in Section 4.

8.4 Wearing of clinical uniform whilst not at work is unacceptable at any time unless travelling to and from work were no work based changing facilities are available.

8.5 Where locker room and changing facilities are available employees must travel to and from work in their own clothes. For area where changing facilities are not provided the uniform must be covered discreetly for the journey to and from the workplace, between patients or on an allocated work break when the employee is off site. The Trust acknowledges that community staff may not be able to effectively cover their uniform whilst travelling between patients in hot weather.

8.6 It is not acceptable to wear uniforms on public transport or off site where the employee is identifiable. This creates risk for the employee, as the public will not differentiate between clinical ability and appropriateness to help. Staff in

uniform off premises may be called upon to act by the public, which may be outside of their experience and scope of practice.

9. Additional Requirements for Uniformed Employees Working in Clinical Areas

9.1 All direct care providing employees, when on duty, should wear their regular uniforms

9.2 Where there are no changing facilities the uniform must be covered discreetly for the journey to and from work and between patients.

9.3 Clothing should allow sufficient hip and shoulder movement for the safe moving and handling requirement of the job.

9.4 Stockings, tights and socks should not detract from the overall appearance of the uniform.

9.5 Neck ties should be tucked in or removed during any care activity which involves patient contact.

9.6 Trust sweatshirts, navy or black cardigans/fleeces may be worn but not when in care/clinical areas/patient areas and/or attending to patients. Clean and dirty/contaminated uniforms must not be stored or transported together because of the risk of cross–contamination. The range of items supplied will be determined by the service manager. Items supplied must comply with this policy.

9.7 Polo shirts may be worn in extreme hot weather conditions as advised by Emergency Planning team. They may also be worn by staff who work in areas of the Trust where managers have agreed they can wear them as an alternative to uniform or own clothes or staff who work in gym areas.

9.8 Staff undertaking Prevention and Management of Violence Training, (PMVA), which is a physical restraint course, are required to wear appropriate gym gear.

9.9 Where a head scarf or a veil is worn, as part of religious belief, employees must ensure that the flow of the garment does not interfere with work practices. This must be changed on a daily basis to minimize cross infection.

9.10 Similarly, any employee who has a need for special consideration to be given to their appropriate clothing due to having a disability, should bring this to the attention of their line manager, seeking support and guidance from Occupational Health, Infection Prevention and Control team and Human Resources as necessary.

10. Non-Clinical Staff who are required to wear a Uniform

10.1 All employees who are required to wear a uniform must wear the uniform provided and agreed by the Trust.

10.2 Non- Clinical Staff who are required to wear a uniform are to comply with the General Principles stipulated in section 4 of this Policy.

10.3 Uniform & Personal Protective Equipment must be worn at all times while at work and be compliant with local departmental instructions. Deficiencies, unsuitable items and or uniform that is worse for wear must be reported immediately to their line managers.

11. Return / Renewal of Uniform

11.1 Renewal of uniforms will be at the discretion of the line manager and linen room supervisor. Requests for new uniforms will be at the discretion of the line manager and linen room supervisor and all old uniforms must be returned when the new uniform is issued. Uniforms will be returned to the Linen room in the Facilities Department when employment ceases.

12. Extreme Weather Conditions

12.1 Any amendment to this policy due to extreme heat conditions, e.g., a decision to allow tailored shorts to be worn in community settings, will be at the discretion of the Chief Nurse. However, Managers should feel empowered to decide and inform the Chief Nurse of their actions and reasoning. Resuming to usual work wear should occur as soon as possible as weather conditions normalise.

13. Clinical Uniform Laundry, Replacement and Disposal Guidance

13.1 Clinical staff who are required to wear a uniform will be provided with an adequate number of uniforms and managers will ensure that uniforms are requested correctly.

13.2 The following guidance should be followed when handling and decontaminating socially soiled uniforms:

- Wash separately from other items, in a washing machine at 60 degrees centigrade wash cycle.
- Wash in a biological detergent in the quantities recommended by the manufacturer • Dry quickly or tumble dry and iron
- Non uniformed direct/indirect care staff should ensure that items of clothing are able to be washed at the highest temperature that the clothing will tolerate.
- Hand washing uniforms is ineffective and therefore not acceptable

13.3 Managers are responsible for ensuring collection of Uniforms from staff who are leaving the organisation. Managers will decide if the Uniform can be reallocated or if they should destroy the Uniform if it is no longer fit for purpose.

13.4 Staff leavers are responsible for returning freshly laundered uniforms to the Line Room.

13.5 Managers will place requests with the linen room supervisor for new unforms if they need replacing.

14. Theatres

14.1 A clean suit must be worn every day by all staff in Theatres

14.2 All staff who wear non-standard scrubs must ensure that they are laundered in line with hospital policy

14.3 Scrub suits must be changed if staff have been in contact with patients with known infections. All suits must be laundered by the hospital accredited laundry service

14.4 Footwear use should follow the guidance in section 5 of this policy and must be anti- static. Clogs are an acceptable footwear option in Theatres as long as they are washed and comply with infection prevention and control guidance.

14.5 In Theatre areas, hats should be worn at all times and all hair completely covered under the hat. Individual cloth hats must be worn and laundered by staff themselves, with white hats for visitors, domestic staff and students

14.6 Theatre masks and hats should be removed upon leaving the department (Caveat; masks are to be kept in place whilst we are working under the Covid-19 IPC rules).

14.7 All staff must change out of theatre scrubs before leaving the theatre department. A **BLUE** disposable over coat which should be fastened must then be worn. Hats and masks must be removed. Shoes must be changed (or overshoes worn).

14.8 No-one is to enter any theatre wearing a white coat. Handbags, cardigans etc must not be taken into clinical areas, including anaesthetic rooms.

14.9 Reference is to be made to section 5 of this policy (general principles) for all Theatre staff

15. Roles and Responsibilities

15.1 Managers and senior leaders must reinforce the standards within the parameters of this policy. This should be disseminated to all members of their teams and managers must ensure that teams understand and adhere to local protocol and the policy requirements. This includes ensuring that:

- Any essential uniform or personal protective equipment identified as a result of a risk assessment is made available for use of staff.
- Local protocols are written for staff to ensure compliance with the service risk assessment.
- Any training required in order to ensure safe use of the equipment is provided.
- Staff are monitored to ensure compliance with the risk assessment and training
- The risk assessment is reviewed on an annual basis • Update training is provided as appropriate
- Uniforms are only purchased from the approved Trust suppliers.

- Ensure that employees are aware of and have access to the correct uniform for their area of work.
- Replacement uniforms are provided as required and in agreement with the line manager and the employee
- Take appropriate action where an employee does not comply with the dress code, appearance or uniform requirements set out in this policy
- Complete the audit tool on an annual basis (Appendix B).

15.2 Staff members must:

- Adhere to the standards of dress and personal appearance to their staff group and job role at all times
- Maintain awareness and comply with this policy
- Inform their line manager in a timely manner should their uniform need replacing
- Inform their manager of any discretionary reasons they may need adjustments to be accommodated to this policy
- Comply with this and any other associated polices
- Attend any training provided in relation to the safe use of personal protective equipment (PPE)
- Wear any uniform and use protective equipment provided in accordance with the risk assessment
- Make uniforms and equipment available for inspection on request of the manager
- Bring to the attention of the manger when uniforms have become worn or need repair / replacement
- Return any uniform or PPE to the manager when the individual leaves their post or no longer requires it
- Notify the manager when they establish that they are pregnant so that a maternity uniform can be provided in a timely manner

15.3 The Human Resource department will provide guidance to managers and employees to ensure the policy is followed fairly and consistently.

15.4 Human Resources will also offer support and advice to both managers and employees who wish to discuss a deviation from the policy due to cultural/religious/medical or personal.

16. Training

16.1 The Uniform Policy is discussed with staff at Trust induction, via mandatory training and at local ward/departmental induction.

17. Equality Impact Assessment and Mental Capacity

17.1 An Equality and Impact Assessment has been completed on this policy and there were no equality issues identified.

18. Success Criteria / Monitoring Effectiveness

18.1 The requirements of this policy will be subject to annual audits. The audit tool can be found in Appendix B.

18.2 Managers are required to report back to their Matrons and local governance committee their finding of the uniform and dress code audits, with action plans as appropriate.

18.3 If a member of staff does not meet the standards of dress code described in the policy, they will be asked not to wear the inappropriate item again. The Trust reserves the right to ask the staff member to go home and change into something more appropriate.

18.4 In circumstances where a staff member persistently breaches the guidelines in this policy, they may face action under the Trust's disciplinary procedure.

19. Review

19.1 This document may be reviewed at any time at the request of either staff side or management but will automatically be reviewed on a three yearly basis unless organisational changes, legislation, guidance, or non-compliance prompt an earlier review.

20. Further Information

Associated Documentation

The main legislation that affects an organisation's response to the transmission of infection via uniforms or work wear is as follows:

- The Health and Safety at Work Act 1974 sections 2 and 3. Section 2 covers risks to employees and section 3 to others affected by their work e.g., patients.
- The control of substances Hazardous to Health Regulations 2002 (COSHH). Further information about COSHH and its applicability to infection control can be found at www.hse.go.uk/biosafety/healthcare.htm
- Management of Health and Safety at work Regulations 1999 (Management Regulations), that extends the cover to patients and others affected by microbiological infections and include control of infection measures.
- "Securing Health together, "The Health and Safety Executive (HSE) long term strategy for occupational health, that commits HSE/Health and Safety Commission and their fellow signatories (including the Department of Health) to a 20 % reduction in ill health caused by work activity by 2010.
- Health Act 2005 Code of Practice, Duty 4 to maintain a clean and appropriate environment includes at section (g) that the supply and provision of linen and laundry reflects Health Service Guidance HSG95 (18), as revised from time to time and at section (h) that clothing (including uniforms) worn by staff when carrying out their duties is clean and fit for purpose.

References

- Department of Health: (2008) The Health and Social Care Act 2008: A Code of Practice for health and adult social care on the prevention and control of infections and regulated guidance. London. Department of Health
- Department of Health: (2007) Uniforms and Work wear: An evidence base for developing local policy. London. Department of Health 2007
- Department of Health: (2010) Uniforms and Work wear; Guidance on uniform and work wear policies for NHS employers. London Department of Health 2010
- Royal College Royal College of Nursing (2013) - Wipe it out- One Chance to get it right: Guidance on uniforms and work wear

Appendix A - Glossary of Terms

Patient

This term is used when referring to the NHS population as a whole. Also, for the purpose of this policy it is used to mean, service user, resident, client etc.

Direct care

This term refers to employees in both clinical and non- clinical settings who give direct hands-on patient care e.g., assisting with personal hygiene, giving injections etc.

Non- direct care

This term refers to employees who do not provide patient care but may refer to employees who have access to / work with patient equipment / patient environment.

Infection Prevention and Control

Is the prevention and management of infection through the application of research-based knowledge to practices that include standards precautions, decontamination, waste management, surveillance and audit.

Appendix B - Audit Tool Link

https://forms.office.com/Pages/ShareFormPage.aspx?id=G888R1c5sE6Cur6KaqH2Su-SE7DNl0BGqE_hZ_0ybkpUNDI3WDNUUjE3Vzg1MUEzQlcwR0ZHVFBKMC4u&sharetoken=FsiOAc6AWaRENd87rI1m

Appendix C – Uniform Colours

(The national uniform review is currently being undertaken. The below chart will be amended for all Trust staff who wear a clinical uniform once the review is complete, and the outcome confirmed)

Equality Impact Assessment

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it. c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Stepwise Guide for Policies when completing this form		
Policy Name	Uniform Policy	
Policy Overview	The policy identifies the necessary clothing principles and requirements that all staff need to follow whether in uniform or not, to ensure compliance with infection control guidance and to portray a professional image to patients and the public.	
Relevant Changes (if any)	Complete rewrite.	
Equality Relevance Select LOW, MEDIUM, or HIGH	LOW	
If the policy is LOW relevance, you **MUST** state the reasons here.	The equality issues associated with this policy are minimal. Those that are applicable are covered detail in the policy.	
Form completed on:	Date: 13/10/2022	
Form completed by:	Name: Phil O'Connor	Job Title: Deputy Director of Nursing

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Phil O'Connor	Job title: Deputy Director of Nursing
Approval Committee:	Infection Prevention and Control Committee	03/11/2022
Ratification Committee:	Clinical Quality Steering Group	08/11/2022
Person to Review Equality Analysis:	Name: Phil O'Connor	Review Date: 08/11/2025
Comments:	Click here to enter text.	

Alder Hey Children's
NHS Foundation Trust

RM70 - ZERO TOLERANCE OF RACIST, HOMOPHOBIC, PREJUDICED OR DISCRIMINATORY BEHAVIOUR

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Quick Reference Guide – Zero Tolerance of any Violent, Aggressive, Inappropriate, Unacceptable, Racist, Homophobic, Prejudiced or Discriminatory Behaviour

The Trust has a duty to protect members of staff, patients and visitors as well as a duty to provide appropriate health care to children and young people. The abuse of our staff is unacceptable and will not be tolerated. **The Trust has a zero tolerance approach to any abuse of staff.** This means that:

- An **action of some form, which may be a sanction,** will be taken in the event of any incident of behaviour felt to be **violent, aggressive, unacceptable or inappropriate** exhibited **by a parent / carer or visitor** as outlined in section x of this policy.
- A **sanction** will be taken in the event of any incident of behaviour felt to be **racist, homophobic, prejudiced or discriminatory** in any way towards our staff, patients or other visitors exhibited **by a parent / carer or visitor** as outlined in Section x of this policy.
- **Appropriate action** will be taken in the event of any incident of behaviour felt to be **violent, aggressive, unacceptable or inappropriate** in any way towards our staff, other patients or other visitors exhibited **by a patient** as patients in this policy) as outlined in Section x of this policy.
- **Appropriate action** will be taken in the event of any incident of behaviour felt to be **racist, homophobic, prejudiced or discriminatory** in any way towards our staff, other patients or other visitors exhibited **by a patient** as outlined in Section x of this policy.

Violent, aggressive, unacceptable or inappropriate behaviour referred to as 'unacceptable or inappropriate' behaviour in the policy.

Racist, homophobic, prejudiced or discriminatory behaviour is referred to as 'discriminatory' behaviour in the policy.

This policy applies to all Trust staff, contractors, volunteers, students and those on placements or work experience who encounter, witness or are informed of any inappropriate, unacceptable or discriminatory behaviour by parents / carers, visitors or patients.

This policy does not apply to staff who behave in a manner felt to be unacceptable, inappropriate or discriminatory. For staff incidents refer to **Disciplinary Policy – E5** (see DMS).

An incident can be prosecuted as a hate crime where an individual has demonstrated hostility, or been motivated by hostility, on the basis of race, religion, disability, sexual orientation, or transgender identity. The Trust will support staff who want to report hate crime to the Police and / or other organisations such as Stop Hate UK, True Vision, and Tell MAMA.

The full Zero Tolerance Process is set out in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS). and defines five stages for managing any such behaviour exhibited by parents or visitors. **This policy escalates immediately to either a formal written warning in line with Stage 3 or exclusion in line with Stage 5 for parents and**

visitors who exhibit overt discriminatory behaviour or intentional subtle microaggressive behaviour.

Where discriminatory behaviour is considered to be unintentional micro-behaviour, and did not cause harm or offense to the staff member, this should be reviewed by an Expert Review Panel where first line management at Stage 1 of the Zero Tolerance Process may in some circumstances be considered appropriate.

If staff feel their safety or the safety of others is compromised at any point they should call Security on 3181 (CHP) or 2004 (Catkin) and / or the Police on 999.

For the purpose of this policy, the term 'incident' relates to all incidents of behaviour felt to be racist, homophobic, prejudiced or discriminatory in any way.

Key responsibilities for Staff

- Report all incidents to line manager and on Ulysses.
- Ensure all incidents are managed in line with the Zero Tolerance Process (Appendices A-D).

Key responsibilities of Ward / Department Managers

- Ensure all incidents are managed in line with the Zero Tolerance Process.
- Ensure all incidents are reported and investigated and that staff are supported.

Key responsibilities of the Equality and Diversity Lead

- Raise awareness about the need to report and investigate all incidents, and ensure that staff are supported. Provide information about reporting incidents to the Police or via other organisations such as Stop Hate UK, True Vision and Tell MAMA
- Monitor and review all incidents and themes. Report to Trust Board Assurance Committee every quarter.

Key responsibilities of the Local Security Management Specialist (LSMS)

- Ensure all reported incidents are thoroughly investigated and the most appropriate action taken against offenders.

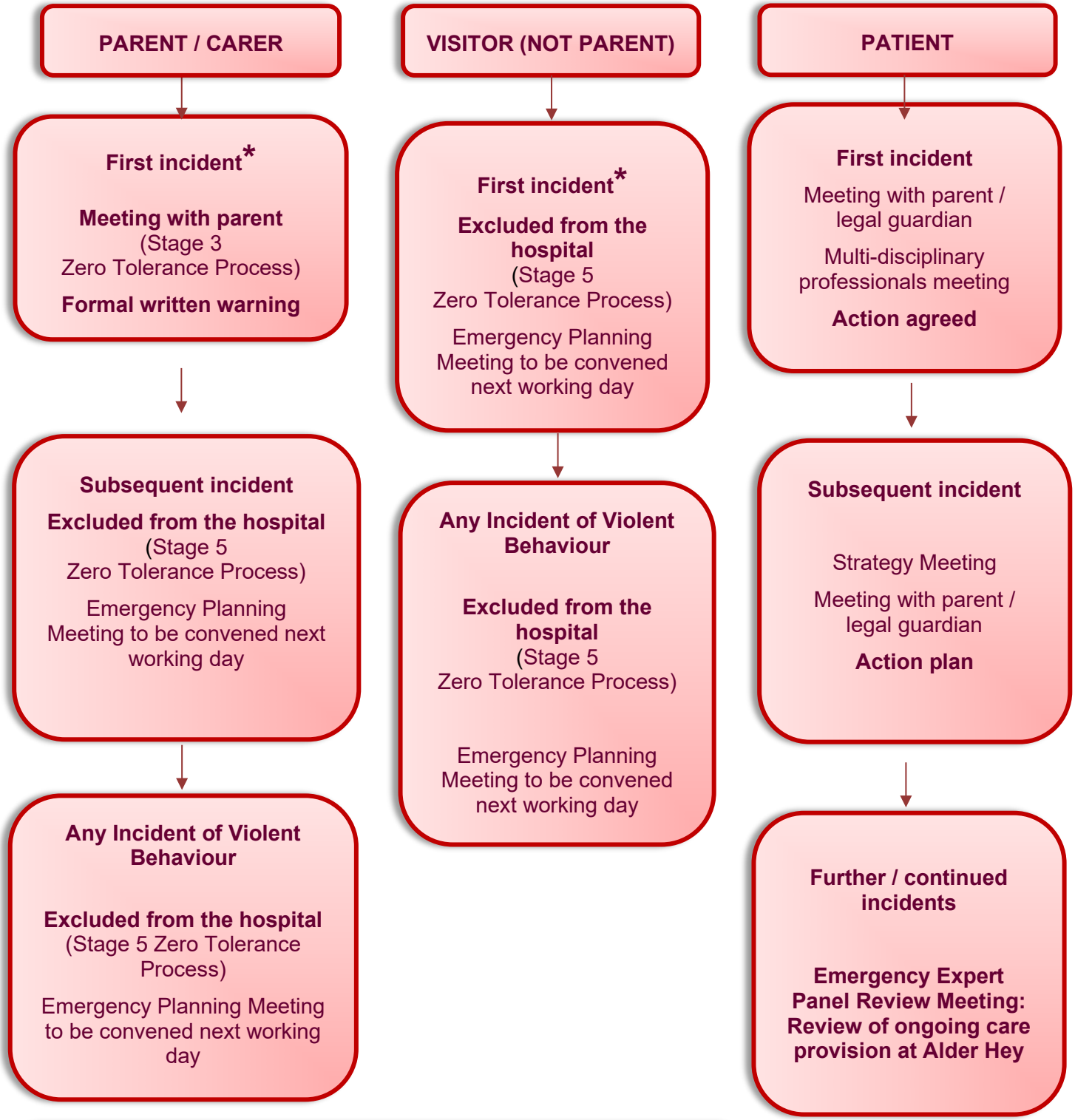
Key responsibilities of the Chief Nurse and Medical Director

- Will Chair Emergency Planning meeting related to exclusion of parents or visitors and will Chair Emergency Expert Panel Review related to review of ongoing care and treatment of a patient exhibiting discriminatory behaviour

Key responsibilities of the Trust Board

- Support sanction of every incident.

Flowchart of Zero Tolerance Process for Racist, Prejudiced or Discriminatory Behaviour



***First incident of discriminatory behaviour considered to be unintentional and did not cause harm**

Meeting with parent / visitor (Stage 1 Zero Tolerance Process)

Expert Review Panel to be convened next working day

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	January 2022	Pauline Brown	Current	New policy commissioned by BAME Task Force

Record of changes made to Zero Tolerance of Racist, Prejudiced or Discriminatory Behaviour			
Section Number	**Page Number**	**Change/s made**	**Reason for change**

Contents

1 Introduction and Key Information

1.1 Behaviour by parents, visitors or patients felt to be racist, homophobic, prejudiced or discriminatory in any way towards our staff, patients or other visitors is abhorrent and will not be tolerated.

1.2 National evidence suggests black, Asian and minority ethnic (BAME) and other under-represented groups of health care staff continue to experience racism and discrimination in the workplace from patients or their families due to their ethnic background (NHS Staff Survey 2020). It is essential that health care staff respond appropriately if they encounter or witness discriminatory or racist behaviour from parents or visitors in line with this policy and do not tolerate the behaviour exhibited towards themselves or a colleague.

1.3 The Trust has a duty to protect members of staff, patients and visitors as well as a duty to provide appropriate health care to children and young people. Alder Hey is dedicated to delivering world class outstanding care for children, young people and their families, and the Trust is staffed by people who are highly committed, caring, empathetic and compassionate. In doing so, it is acknowledged that the staff may be exposed to, and have at times tolerated, behaviour felt to be racist, homophobic, prejudiced or discriminatory in order to achieve the best outcome for their patient. This policy is designed to support all staff as racism and discrimination must not be tolerated in any circumstances.

1.4 Overt discriminatory behaviour is a criminal offense. An incident can be prosecuted as a hate crime where an individual has demonstrated hostility, or been motivated by hostility, on the basis of race, religion, disability, sexual orientation, or transgender identity. The Trust will support staff to report to the Police and / or contact relevant supportive organisations such as Stop Hate UK.

1.5 Any concern raised by a staff member who has experienced or witnessed discriminatory behaviour will:

- Be believed
- Be listened to
- Be supported
- Be taken extremely seriously on every occasion
- Be valid
- Be managed in line with the Zero Tolerance process outlined in this policy.

1.6 Discriminatory behaviour exhibited by a parent / carer is a significant safeguarding concern, as not only may their child / children learn and adopt such intolerable behaviour, but the manifestation of such behaviour in the Trust may impact upon and interfere with our ability to provide essential clinical care. A safeguarding referral must be made for any incident of overt or subtle microaggressive discriminatory behaviour.

1.7 The Trust operates zero tolerance, which means that action or a sanction will be made every time for any reported or witnessed behaviour instigated by parents or visitors felt to be racist, homophobic, prejudiced or discriminatory.

The full Zero Tolerance Process is set out in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) and defines five stages for managing any such behaviour exhibited by parents or visitors.

1.8 Prejudicial behaviour can be exhibited in various ways as outlined in Section 1.12. Such behaviour may be overt discrimination or more subtle microaggression(s); subtle behaviour does not suggest that the individual does not intend to cause harm by their behaviour and can be as equally offensive and harmful as overt behaviour. Overt discriminatory behaviour and subtle microagression(s) deemed to be intentionally discriminatory, will be managed in line with Section 1.10 and Section 5 Stage 3 or Stage 5 of the Zero Tolerance Process. Overt discriminatory behaviour is a criminal offense.

1.9 It is recognised that there may be occasions where a member of staff believes the behaviour or micro-behaviour exhibited by the individual, that they personally experienced or witnessed, was not intended to be harmful and did not cause any harm or offense; this does not include overt discriminatory behaviour. This does not mean that the behaviour will be tolerated or condoned, however in such circumstances it is reasonable to review and determine the level of intent to cause harm. In such circumstances it may be considered appropriate to take a different and more proactive and educational approach in the first instance than that in place to manage overt discriminatory behaviour or subtle microaggression with intent, and this is outlined in Section 1.9 and Section 5. It is important that any such incident is reviewed by the Expert Review Panel, which is an independent diverse group (see section 5.4). There is the potential that the individual staff member may not take offense to a comment or behaviour that another staff member would be offended by, potentially due to individual higher thresholds for tolerance based on previous experiences of being exposed to discriminatory behaviour, and a wider view may determine that the behaviour should be managed in line with Stage 3 of the Zero Tolerance Process. All incidents must be documented in the patient's health record so that no incident or pattern of behaviour goes undetected or unmanaged.

1.10 A first incident reviewed and determined to be unintentional micro-behaviour that did not cause harm or offense may be managed in line with Stage 1 or Stage 3 of the Trust Zero Tolerance Process as set out in section 5:

i. Parents: First incident: meeting and action plan (Stage 1)

Subsequent incident: final written warning (Stage 3)

ii. Visitor: First incident: meeting and action plan (Stage 1)

Subsequent incident: exclusion (Stage 5)

1.11 Incidents of overt and intentional microaggressive racist, homophobic, prejudiced or discriminatory behaviour exhibited by parents or visitors will be managed in line with Stage 3 or Stage 5 of the Trust Zero Tolerance Process as set out in Section 5.

i. Parents: First incident: final written warning (Stage 3)

Subsequent incident: exclusion (Stage 5)

ii. Visitor: First / any incident: exclusion (Stage 5)

1.12 Children and young people (referred to as 'patients' in this policy) may exhibit behaviour felt to be racist, homophobic, prejudiced or discriminatory towards staff, other patients or other visitors. Such behaviour is unacceptable, should not be excused, and must be addressed. Therefore the Trust will take appropriate action in all incidents as outlined in Section 6.

1.13 Identifying the potential cause of why a patient exhibits racist, homophobic, prejudiced or discriminatory behaviour does not in any way accept or condone such behaviour, however an understanding of the potential causes can assist the Trust to take the most appropriate action as outlined in Section 6. The Lead Consultant would identify if there is an identifiable or potential clinical cause for the patient's behaviour. Potential causes may include, though are not limited to:

i. **Learned behaviours:** Children and young people may be exposed to racist, homophobic, prejudiced or discriminatory behaviour in their current home and / or social life, or in their previous background, which they may learn and replicate.

ii. **Acquired head injury:** Leading to altered or unpredictable behaviours which may be temporary, longer term, changing and evolving. A dynamic Risk Assessment will be required.

iii. **Additional needs and / or challenging behaviour:** Patients who may experience higher levels of distress due to, for example, mental ill health, Autistic Spectrum Disorder, learning disability, communication difficulties.

iv. **Effects of prescribed medication:** For example disorientation following anaesthesia or weaning from analgesia and sedation.

1.14 Attitudes and behaviours that are considered racist, homophobic, prejudiced or discriminatory include, but are not limited to:

i. Offensive or obscene language or behaviour related to a person's race, colour, ethnic background, gender, nationality, religion, disability, age, sexual orientation or appearance

ii. A parent or visitor saying they do not want their child to be cared for or treated by a staff member of a different colour or ethnic background

iii. Microaggressions; brief and commonplace daily verbal, behavioural or environmental indignities that communicate hostile, derogatory, or negative attitudes. These can be intentional, or unintentional without meaning to cause harm or offense.

1.15 A hate crime is any criminal offense which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability; race, religion, sexual orientation or gender identity or perceived race,

religion, sexual orientation or gender identity An incident can be prosecuted as a hate crime where an individual has demonstrated hostility, or been motivated by hostility, on the basis of race, religion, disability, sexual orientation, or transgender identity

Examples include:

i. Physical attacks such as:
   - Physical assault
   - Damage to property or graffiti

ii. Threat of attack such as
   - Inciting hatred by words, pictures or videos
   - Offensive letter,
   - Abusive or obscene telephone call,
   - Intimidation
   - Unfounded malicious complaints

1.16 A hate incident is any non-criminal incident which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability; race, religion, sexual orientation or gender identity or perceived race, religion, sexual orientation or gender identity An incident can be prosecuted as a hate crime where an individual has demonstrated hostility, or been motivated by hostility, on the basis of race, religion, disability, sexual orientation, or transgender identity

Examples include:

i. Verbal or online abuse
ii. Insults or harassment, such as taunting
iii. Abusive gestures

1.17 Regardless of precise definitions, staff should report any incident they consider to be racist, homophobic, prejudiced or discriminatory in any way

1.18 Incidents can occur either in person face to face, by telephone, letter, e-mail, text, social media or another form of communication such as graffiti on personal or NHS property.

1.19 Alder Hey staff have considered and identified that on rare occasions there may be circumstances where there is a potential for an individual staff member to misunderstand an interaction as prejudicial behaviour, or individual staff perception of an interaction constituting prejudicial behaviour. This is not to negate or diminish how that individual staff member who experienced or witnessed the interaction thinks or feels and staff will always be believed, listened to, and supported. The Trust recognises that the effect of the perception of racism is equal to the effect of actual racism.

In such rare circumstances it is recommended that a review of the interaction by the Expert Review Panel, formed of a diverse group of staff, should take place by the next working day following the interaction being reported, resulting in a recommendation of how the parent or visitor is managed in line with the

Zero Tolerance Process, and support for the individual member of staff. An explanation, including an admission and apology by the person who was the source of the perception of racism, may be considered more appropriate in line with Stage 1 of the Zero Tolerance Process. It is reasonable to expect that where there has been any perception of racism, and the parent / visitor did not mean to cause harm or offense, that most individuals would voluntarily proffer an immediate, full and unreserved apology for their inadvertent action and provide assurance that there will be no repeat of such behaviour in the future given that this was perceived or understood to be discriminatory. A proactive and educational approach should be put in place to support the parent / visitor going forward.

1.20 It is important that actions outlined in this policy are applied quickly, fairly and consistently and it is recognised that some staff may require additional support and / or training in making a decision or speaking to a family member, for example. Members of the Expert Review Panel will be able to support, assist and advise as required.

1.21 If you are concerned that an individual's behaviour is suggestive of them being radicalised, this should be managed in line with **Prevent Policy – RM19** (see DMS). Staff should discuss their concerns with their immediate line manager and the Safeguarding Lead / PREVENT Lead / Safeguarding Specialist Nurses.

Concern that an individual may be vulnerable to radicalisation does not mean that you think the person is a terrorist. It means that you are concerned they are prone to being exploited by others, and so the concern is a safeguarding concern.

1.22 This policy applies to all Alder Hey Children's NHS Foundation Trust staff, temporary and agency staff, contractors, students and those on placements or work experience.

1.18 This policy does not apply to the management of any staff member who behave in a manner felt to be racist, homophobic, prejudiced or discriminatory. This should be managed in line with **Disciplinary Policy – E5.** (see DMS)

2 Definitions

2.1 *Parent*: The term will refer to parents, carers and legal guardians who have parental responsibility.

2.2 *Other visitors:* The term will refer to family, friends and other visitors.

2.3 *Patient:* The term will refer to any child or young person we provide care and treatment to in any setting.

2.4 *Prejudice:* Dislike, hostility or unjust behaviour deriving from preconceived and unfounded assumptions or opinions based on the individual's membership or perceived membership to a social group

2.5 *Discrimination:* The practice of unfairly treating a person or group differently from other people or groups of people. Unjust or prejudicial negative behaviour

or actions towards an individual or group of people on the basis of race, religion, disability, sexual orientation, transgender identity, or age

2.6 *Hate crime:* Is any criminal offense which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation; or transgender or perceived transgender identity An incident can be prosecuted as a hate crime where an individual has demonstrated hostility, or been motivated by hostility, on the basis of race, religion, disability, sexual orientation, or transgender identity (Crown Prosecution Service)

2.7 *Hate incident:* Is any non-criminal incident which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation; or transgender or perceived transgender identity An incident can be prosecuted as a hate crime where an individual has demonstrated hostility, or been motivated by hostility, on the basis of race, religion, disability, sexual orientation, or transgender identity

2.8 *Overt:* Done or shown openly or publicly or in an obvious way; plainly apparent and not secret

2.9 *Micro-aggression / micro-aggressive:* Patterned behaviours by individuals in a majority group that undermine, belittle, stereotype, or insult those in a minority group

2.10 *Micro-behaviours: Are tiny, often unconscious, gestures, facial expressions, postures, words and tone of voice which can influence how included or not included people feel*

2.11 *Incident:* The term will refer to any behaviour felt to be racist, homophobic, prejudiced or discriminatory in any way.

2.12 *Such behaviour:* The term will refer to any behaviour felt to be racist, homophobic, prejudiced or discriminatory in any way.

3. Purpose of the Policy

3.1 To promote the Trust values and a culture of racial harmony that does not tolerate incidents either experienced or witnessed.

3.2 To provide staff with guidance on how to manage incidents in the workplace, including a clear Zero Tolerance Process, procedures and formal template letters to invoke following any incident.

3.3 To promote reporting of incidents through the Trust's Ulysses incident reporting system.

3.4 To support staff who experience or witness hate crime or hate incidents to report to the Police.

3.5 To support and signpost staff who do not want to report to the Police to other relevant organisations such as:

- Stop Hate UK
- True Vision
- Tell MAMA

4 Duties

4.1 All Staff

i. Do not tolerate or accept racist, homophobic, prejudiced or discriminatory behaviour towards yourself or towards others that you bear witness to. You have a right to work free from any abuse.

ii. Escalate any incident by any parent, visitor or patient to the person in charge and / or your line manager, and to the patient's Lead Consultant

iii. Document any incident in the relevant patient's health record, irrespective of the individual's relationship to the patient

iv. In liaison / led by your line manager, manage any incidents by parents or visitors in line with the Zero Tolerance Process outlined in Section 5.

v. In liaison / led by your line manager and the patient's Lead Consultant, manage any incidents by patients as outlined in Section 6 of this policy.

vi. Report all incidents via the Ulysses incident reporting system.

vii. Report incident to the Safeguarding Team.

viii. **If you feel your safety or the safety of others is compromised at any point call Security on 3181 (CHP) or 2004 (Catkin) and / or the Police on 999.**

4.2 Ward / Departmental Managers / Service Leads / Heads of Service

i. Ensure all incidents are reported via Ulysses and investigated.

ii. Ensure all incidents are documented in the patient's health record, irrespective of the individual's relationship to the patient.

iii. Manage any incident by parents or visitors in line with the Zero Tolerance Process outlined in Section 5 and in line with the escalation process.

iv. In liaison with the patient's Lead Consultant, manage any incident by patients as outlined in Section 6 of this policy and in line with the escalation process.

v. Ensure incident reported to Safeguarding Team.

vi. If you feel your safety or the safety of others is compromised at any point call Security on 3181 (CHP) or 2004 (Catkin) and / or the Police on 999.

vii. Ensure all staff are supported following any incident by seeking appropriate advice from the LSMS, Police, Equality and Diversity Lead, and Trust Legal Services and following **Supporting Staff Policy – RM49** and **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS)

viii. Ensure appropriate resources about the Trust values and zero tolerance of racist behaviour is available and accessible to parents and visitors. This includes, though is not limited to:

- Welcome posters / signage
- Ward information leaflets / booklets
- Vistors and Relatives Charter
- Zero tolerance posters / signage

4.3 Patient's Lead Consultant

i. In addition to duties for 'All Staff', provide key clinical leadership, clinical judgement and clinical decision making for the care and treatment of the patient who is felt to be exhibiting racist, homophobic, prejudiced or discriminatory behaviour as outlined in Section 6. This includes identifying if there is an identifiable or potential clinical cause for the patient's behaviour.

4.4 Divisional Triumverate Leads

i. Responsible to the Board for the effective implementation of this policy and all associated procedures.

ii. Support staff in managing incidents in line with the Zero Tolerance Process for parents and visitors (see Section 5), and for any incidents involving patients (see Section 6).

4.5 Chief Nurse and Medical Director

i. In the event of invoking parent or visitor exclusion in line with Stage 5 of the Zero Tolerance Process (section 5.10), Chair an Emergency Planning Meeting on the next working day

ii. In the event of a second incident of discriminatory behaviour by a patient, review the proposed outcome of the Strategy Meeting outlined in Section 6.2 to review, agree and sign off as an appropriate and proportionate plan.

iii. In the event of a further incident of discriminatory behaviour by a patient, Chair an Emergency Expert Panel Review meeting on the next working day to review ongoing care arrangements for the patient

iv. Inform the Chief Executive of any decision to discharge, delay, postpone or withhold treatment from a patient due to discriminatory behaviour, and inform of onward arrangements and timescales for future review.

4.5 **Equality and Diversity Lead / Human Resources**

i. Raise awareness about the need to report and thoroughly investigate all incidents and advise on the most appropriate action to be taken in line with the Zero Tolerance Process outlined in Section 5 regarding incidents involving parents or carers, or Section 6 for incidents involving patients.

ii. Support staff involved in an incident. Provide information about reporting incidents to the Police or via other organisations such as Stop Hate UK, True Vision and Tell MAMA

iii. Monitor and review all incidents and themes. Report to the People and Wellbeing Trust Board Assurance Committee every quarter.

4.6 **Local Security Management Specialist (LSMS)**

i. Ensure all reported incidents are thoroughly investigated and the most appropriate action taken in line with the Zero Tolerance Process outlined in Section 5 and reported to the Police as appropriate.

ii. Consider whether the Trust should initiate private prosecution and / or civil proceedings where an incident relating to a parent or visitor has been reported to the police and the police have decided not to pursue the matter.

4.7 **Trust Board**

i. Support staff to fully implement this policy and all associated procedures.

5. Managing Behaviour by Parents or Visitors felt to be Racist, Homophobic, Prejudiced or Discriminatory: Zero Tolerance Process

5.1 The Zero Tolerance Process provides guidance to staff on the appropriate action to take in the event of an incident of discriminatory behaviour. Any incident of discriminatory behaviour must be addressed. Discriminatory behaviour that is overt or a subtle intentional microaggression, will be managed in line with at least Stage 3 of the Zero Tolerance Process. Threatening or violent behaviour in person or by other means of communication will be managed in line with Stage 5 of the Zero Tolerance Process. The guidance may differ depending upon whether the overt behaviour is displayed by a parent or other visitor; as parents are usually integral to the care and wellbeing of their child a final written warning (Stage 3) may be appropriate rather than escalating straight to a sanction of exclusion (Stage 5) whereas the Trust will proceed direct to exclusion (Stage 5) for other visitors.

5.2 Discriminatory behaviour exhibited by a parent / carer is a significant safeguarding concern, as not only may their child / children learn and adopt such intolerable behaviour, but the manifestation of such behaviour in the Trust may impact upon and interfere with our ability to provide essential clinical care. A safeguarding referral must be made for any incident of overt or subtle microaggressive discriminatory behaviour managed in line with Stage 3 or Stage 5 of the Zero Tolerance Process. There may be occasions where a

safeguarding referral is deemed appropriate at Stage 1 of the Zero Tolerance Process.

5.3 It is recognised that there may be occasions where Trust staff believe the behaviour or micro-aggressive behaviour exhibited by the individual, that they experienced or witnessed, was not intended to be harmful and did not cause any harm or offense; this does not include overt discriminatory behaviour. This does not mean that the behaviour will be tolerated or condoned and the behaviour must be addressed, however in such circumstances it is reasonable to review and determine the level of intent to cause harm.

Where the behaviour of the parent / visitor was not understood to be intentional or to cause harm or offense, it is reasonable to expect that most individuals, in a discussion with the most appropriate staff member, would proffer a full and unreserved apology for their action and provide assurance that there will be no repeat of such behaviour in the future.

It may be considered appropriate to take a more supportive, proactive and educational approach in the first instance than that in place to manage overt discriminatory behaviour or subtle microaggression with intent. Where there is doubt regarding the threshold of the behaviour, the response of the parent / carer, or appropriate action to take, the Expert Review Panel will review the incident. It is important that an objective review is undertaken, as there is the potential that some staff may not take offense to a comment or behaviour that another staff member would, due to, for example, individual higher thresholds for tolerance based on previous experiences of being exposed to discriminatory behaviour, and a wider view may determine that the behaviour should be managed in line with Stage 3 of the Zero Tolerance Process.

5.4 An Expert Review Panel, will receive additional training to support them to review any reported incidents of discriminatory behaviour where the threshold for management escalating straight to at least Stage 3 is not clear or agreed, as outlined above and in section 1.8 and 1.15. Each panel will be comprised of:

- Representative from the most appropriate Trust network for example BAME; Disability; LGBTQIA+
- Equality and Diversity Lead
- Deputy Medical Director or Divisional Medical Director
- Director of Nursing / Director of AHPs or Associate Chief Nurse
- Trained staff member available for the panel

5.5 **If you feel that the safety of staff or patients is compromised at any time, get help from a senior colleague, call Security on 2004, and call the Police on 999 as required.**

On the **first incidence** where a **parent or visitor** exhibits discriminatory behaviour which is not felt to be intentional and does not cause harm to the member(s) of staff, this may be appropriate to manage in line with Stage 1 of the Zero Tolerance Policy. A discussion must take place with the parent / visitor by an appropriate staff member. The response of the parent / visitor may be suggestive of further action required; for example whether they recognise the

behaviour could cause offense and immediately apologise, or not. The Emergency Expert Panel will review to consider and determine whether a more proactive and educational approach should be considered in line with Stage 1 of the Zero Tolerance Process or whether the behaviour must be managed in line with at least Stage 3 of the Zero Tolerance Process Appendix A: Procedure to follow for racist, homophobic, prejudiced or discriminatory behaviour by parents / carers / legal guardians. A proactive educational approach does not negate or condone the behaviour.

5.6 For **any subsequent incidents** where a **parent or visitor** exhibits discriminatory behaviour which is not felt to be intentional, **following implementation of the agreed plan,** escalate to a meeting with the parent and issue a **Final Written Warning** in line with **Stage 3** of the Zero Tolerance Process Appendix A: Procedure to follow for racist, homophobic, prejudiced or discriminatory behaviour by parents / carers / legal guardians.

5.7 On the **first incidence** where a **parent** exhibits overt or subtle intentional racist, homophobic, prejudiced or discriminatory behaviour, escalate to a meeting with the parent and issue a **Final Written Warning** in line with **Stage 3** of the Zero Tolerance Process Appendix A: Procedure to follow for racist, homophobic, prejudiced or discriminatory behaviour by parents / carers / legal guardians.

5.8 For **any subsequent incident** where a **parent** exhibits overt or subtle intentional racist, homophobic, prejudiced or discriminatory behaviour, escalate to **exclusion** in line with **Stage 5** of the Zero Tolerance Process Appendix A: Procedure to follow for racist, homophobic, prejudiced or discriminatory behaviour by parents / carers / legal guardians.

5.9 For **any incident** where a **visitor** exhibits overt or subtle intentional racist, homophobic, prejudiced or discriminatory behaviour, escalate immediately to **exclusion** in line with **Stage 5** of the Zero Tolerance Process Appendix B: Procedure to follow for overt or subtle intentional racist, homophobic, prejudiced or discriminatory behaviour by a visitor.

5.10 Where a **parent or visitor** exhibits **violent behaviour**, or the **threat of violence** is considered to be significant, escalate immediately to **exclusion** in line with **Stage 5** of the Zero Tolerance Process Appendix C: Procedure to follow for violent behaviour by any visitor including parents.

5.11 Where a **parent or other individual** uses **threatening** or racist, homophobic, prejudice or discriminatory language **over the phone**, they must inform the caller that their language is not acceptable and terminate the call. Just as in the case of threatening behaviour in person, escalate to **exclusion** in line with **Stage 5** of the Zero Tolerance Process Appendix D: Procedure to follow for threatening or offensive language over the telephone by any individual including parents

5.12 Staff who experience or witness the incident must fully document in the patient's health record and complete a Ulysses incident form.

5.13 Ensure all staff are fully supported at every stage of the process in line with the Supporting Staff Policy. This includes, but is not limited to, internal support from

their Line Manager, the SALS Service, HR, a member of the Expert Review Panel, or a member of a Trust Network for example BAME; Disability; LGBTQIA+. Ensure staff are supported to access external support including reporting to the Police or other relevant organisations such as, but not limited to, Stop Hate UK, True Vision, Tell MAMA

5.14 It is acknowledged that there may be a reluctance from some staff to impose sanctions, particularly by staff who feel they experience racist or prejudicial behaviour on a frequent basis and have adopted practices to deal with such inappropriate behaviour, however it is unacceptable and must not be tolerated.

5.15 It is acknowledged that some staff may find it difficult, challenging or impossible to continue to care for a patient where a parent or visitor has exhibited discriminatory behaviour towards them, and they may reasonably request not to be involved in the patient's care going forward. This consideration, choice and decision is individual to each staff member who experiences discriminatory behaviour and therefore there is no set standard. All staff, irrespective of their decision, will be fully supported by the Trust.

Some staff may feel able to continue to provide care to the patient where they feel assured by the robust management and action taken to address the discriminatory behaviour, in line with this policy, that will ensure the behaviour is neither repeated again or will result in the most serious of sanctions if repeated.

Where a staff member feels unable to continue to be involved in care, the staff member can review their decision at any time in the future care provision of the patient if they feel safe and comfortable to be involved in their care again.

Where a staff member's decision not to be involved in care affects the Trust's ability to continue to care for a patient, for example a specialist stand alone practitioner or clinician, this may determine the need to transfer the care of the child as outlined in section 6 of this policy.

5.14 Where exclusion has been invoked, an Emergency Planning Meeting must be set up on the next working day. Please refer to the process set out in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) Section 6.5. The process will include a review of how long a period of exclusion will be set for.

5.15 Refer to other specific or relevant policies and procedures including:

i. Supporting staff (**Supporting Staff Policy - RM49** on DMS)

ii. Incident reporting (**Incident Reporting and Management Policy - RM2** on DMS)

iii. Safeguarding (**Safeguarding Policy - M3** on DMS)

6. Managing Behaviour by Patients felt to be Racist, Homophobic, Prejudiced or Discriminatory

6.1 Initial incident of Discriminatory Behaviour by a Patient

6.1.1 A patient may exhibit racist, homophobic, prejudiced or discriminatory behaviour as outlined in Section 1.7. This may be an isolated incident or uncharacteristic behaviour if linked to a head injury or medication, however may be more sustained behaviour if the patient has been exposed to such abhorrent behaviour in their personal life which they have learned and adopted. The Trust does not tolerate or accept such incidents, irrespective of the cause, and will take the most appropriate action to address the behaviour (Appendix A) but also to assist the patient to stop exhibiting such behaviour.

6.1.2 Prejudicial behaviour exhibited by a patient is more likely to be overt than subtle microaggression. A safeguarding referral must be made for any incident of overt discriminatory behaviour by a patient.

6.1.2 Where a patient exhibits such behaviour, the patient must be told that this is not acceptable and must not happen again. This may be by the staff member who experienced or witnessed the incident if they feel safe to do so, or by their Line Manager if the staff member does not feel safe to address.

i. In cases where the discriminatory behaviour is uncharacteristic, it is reasonable to expect that the parent would react with appropriate consternation and speak to their child themselves, being clear that the behaviour is unacceptable and why, and must not be repeated.

ii. Where the parent does not react in an expected way and speak to their child immediately, which may be an indication that the patient has learned such discriminatory behaviour, the parent and patient must be informed that the behaviour is not acceptable and must stop immediately.

6.1.3 The incident must be reported on Ulysses, documented in the patient's health record, escalated to the staff member's Line Manager and the Lead Consultant informed.

6.1.4 Where the cause of the behaviour is uncharacteristic and understood to be linked to the child's clinical condition, for example following head trauma, a robust clinical, educational and psychological management plan must be set out, agreed and monitored through a Multi Disciplinary Professionals meeting.

6.1.5 A meeting between the Lead Consultant, Ward Manager / Team Leader must take place with the patient's parent following the incident. In the event the patient is looked after, Social Services (holding majority parental responsibility) will be informed and asked to meet with health professionals urgently. The purpose of the meeting will be to:

i. Be clear that the behaviour is unacceptable and will not be tolerated

ii. Provide the patient and family with links to education sources and appropriate links to support eradication of the behaviour

iii. Refer the patient to additional services, such as Learning Disability nurses / ASD nurses / CAMHS Practitioners / Psychology Team, as appropriate

iv. Review the patient's treatment plan and provide an update preceding or following the Multi Disciplinary Professionals meeting as outlined in Section 6.2.

v. Where the incident is not understood to be linked to the patient's condition, be clear that following the implementation of the above agreed actions, together with their support as parents, it is expected that no further incidents of discriminatory behaviour will occur. Be clear that should any further incident occur this may result in the review of care and treatment at Alder Hey.

vi. Inform that a Safeguarding referral will be made and that the Safeguarding team will liaise with the patient's school.

6.1.6 A letter must be sent to the parent with the outcome of the meeting and actions agreed.

6.2 Second incident of Discriminatory Behaviour by a Patient

6.2.1 If a second incident occurs, a Strategy Meeting must be held between the following multi-agency professionals to review the incidents, review the action taken and agreed so far, and devise an action plan:

- Divisional Associate Medical Director or Associate Chief Nurse
- Lead Consultant
- Ward Manager
- Matron or Head of Nursing
- Safeguarding Associate Director or Deputy
- Key clinicians involved in care for example psychologist
- Social Worker (if allocated)

6.2.2 The proposed outcome of the Strategy Meeting must be escalated and reviewed by the Chief Nurse and / or Medical Director to sign off as appropriate and proportionate.

6.2.3 The parent / legal guardian must be informed of the outcome of the meeting and the plan must be shared with them. Clear timescales to review progress must be set with the parents / legal guardian.

6.2.4 Any mitigating factors felt to be the cause / contributing to discriminatory behaviour, for example acquired brain injury; will be clearly identified and addressed in the action plan and the patient's treatment plan

6.2.5 A letter must be sent to the parent with the outcome of the meeting and actions agreed.

6.3 Further incident of Discriminatory Behaviour by a Patient

6.3.1 Where a further incident of racist, homophobic, prejudiced or discriminatory behaviour is exhibited by a patient, an Emergency Expert Panel Review meeting must be convened by the Chair of the initial Strategy Meeting. The

meeting will be Chaired by the Chief Nurse of Medical Director on the next working day.

6.3.2 The parents / legal guardian must be informed that despite a clear agreed action plan that discriminatory behaviour has continued to be exhibited by the patient and the Trust has convened an Emergency Expert Panel Review meeting.

6.3.2 The Emergency Expert Panel Review meeting will be made up of an appropriate expert professional panel which includes:

- Chief Nurse and / or Medical Director
- Deputy Medical Director
- Divisional Associate Medical Director and / or Associate Chief Nurse
- Lead Consultant
- Speciality clinical staff
- Ward Manager
- Matron or Head of Nursing
- Safeguarding Associate Director or Deputy
- Key clinicians involved in care for example psychologist
- Social Worker (if allocated)

6.3.3 The purpose of the Emergency Expert Panel Review meeting will be to review and consider the ongoing care and treatment of the patient provided by staff at Alder Hey due to further repeated and continued discriminatory behaviour being exhibited by the patient.

6.3.4 At all times, the best interests and safety of the individual patient, and the safety of the staff, other patients and visitors will remain of paramount importance. Additional support and advice may be required from the legal team and / or the Trust Ethics Committee.

6.3.5 The Emergency Expert Panel Review meeting will review the incidents that have occurred and the action taken and agreed to date. The following considerations should be taken into account in reaching a decision:

i. Ongoing concern for the safety of staff, other patients and other visitors

ii. Recommendations or instructions from external agencies: Police; Social Services

iii. The clinical condition of the patient

iv. Can care be provided elsewhere

6.3.6 It may be considered appropriate by the review panel to review the ongoing care and treatment of the patient provided by staff at Alder Hey. This must include senior clinical review and clinical decision making by the Lead Consultant. Options for consideration may include:

i. Discharge home

ii. Delay to treatment

iii. Postponement of treatment

iv. Withholding of treatment

6.3.7 Where a decision is made to **discharge the patient home**, a clear discharge plan must be set which ensures the ongoing safety of the patient. In the event that further future review of the patient is required, this must be reviewed and the following must be considered and agreed:

i. Inform the parents / legal guardian of the decision to discharge the patient home and why. Inform the parents of the onward plan

ii. Inform the patient's GP of the incident

iii. Can follow up Out Patient care be provided at Alder Hey or will the patient be referred to another provider. Consider the impact of the action being taken and the response of the parents when setting timescales

iv. Referral to other external agencies as appropriate and inform of the incidents

6.3.8 Where a decision is made to **delay treatment**, a clear plan must be set which ensures the ongoing safety of the patient.

i. Inform the parents / legal guardian verbally and in writing of the decision to delay the treatment and why. Inform the parents of the onward plan

ii. Clearly identify how long treatment will be delayed for; it is expected that where a decision has been reached to delay treatment that this is clinically safe to do so. Where a timescale for delay is not clinically safe, and further action is deemed justified, proportionate and appropriate, the patient will need to be transferred to another care provider to avoid delay in required clinical care

iii. Clearly set out behaviour contract for when treatment resumes

6.3.9 Where a decision is made to **postpone treatment**, a clear plan must be set which ensures the ongoing safety of the patient.

i. Inform the parents / legal guardian verbally and in writing of the decision to postpone treatment and why. Inform the parents of the onward plan

ii. Clearly identify how long treatment is postponed for

iii. Clearly set out behaviour contract for when treatment resumes

6.3.10 In extreme circumstances it may be considered justified and proportionate to **withhold care and treatment** to the patient. Where a decision is made to withhold care and treatment, a clear plan must be set which ensures the ongoing safety of the patient which considers the following:

i. Can the patient be safely discharged

ii. Does the patient have ongoing / long term care needs requiring transfer of care to another provider?

iii. How long is the transfer of care for? This may be for the duration of the care episode for example a short term acute admission. In the event that the patient has complex and ongoing health needs, the decision to transfer care must include an agreed and proportionate timescale

iv. Inform the parents / legal guardian verbally and in writing of the decision to withhold care and treatment and why. Inform the parents of the onward plan

v. Confirm that in a situation where the patient needs to attend the Emergency Department (ED) in an emergency, that in the interests of the patients safety the patient will be seen, treated and then reviewed regarding subsequent care arrangements.

6.3.11 All above options must have a clearly defined timescale. When the decision to lift the care exclusion has been made, it is important to agree an ongoing plan and behaviour contract with the patient and parent in order to minimise the potential for further discriminatory behaviour.

6.3.12 The Chief Executive must be informed by the Chief Nurse and / or Medical Director of any decision to discharge, delay, postpone or withhold treatment from a patient due to discriminatory behaviour, and be informed of onward arrangements and timescales for future review.

6.3.12 The Director of Communications must be informed of any decision to discharge, delay, postpone or withhold treatment from a patient due to discriminatory behaviour, in the event of media interest.

6.3.13 Where the Trust reaches a decision that it is unable to continue to provide care for the patient, this is an extremely complex safeguarding issue as there is the risk that the parent / carer may take their child out of the health care system.

The Safeguarding Associate Director or Deputy will ensure the need for social services overview is made explicit.

6.3.14 Refer to other specific or relevant policies and procedures including:

i. Zero Tolerance (**Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy - RM9** on DMS. Particularly section 7).

ii. Safeguarding (**Safeguarding Procedures - M3** on DMS)

iii. Supporting Staff (**Supporting Staff Policy - RM49** on DMS)

iv. Incident Reporting (**Incident Reporting and Management Policy - RM2** on DMS)

v. Tier 4 CAMHS Policies (on DMS)

vi. **Looked After Children Policy - M65** (on DMS)

vii. **Prevent Policy – RM19** (on DMS)

7. Training

7.1 All staff are required to undertake Equality and Diversity training and Conflict Resolution training in line with the Equality, Diversity and Human Rights Policy – E1 and the Mandatory Training Policy M31

7.2 Staff who form part of the Expert Review Panel should undertake additional training with the Equality and Diversity Lead.

7.3 Training should be offered to all staff to promote equality as a human righr, and empower to report, tackle, challenge and manage discriminatory behaviour

8. Monitoring

8.1 The Equality and Diversity Lead and LSMS are informed of all reported incidents via the Ulysses incident reporting system.

8.2 All reported incidents are reviewed by the Divisional Management Team and may be subsequently reviewed at the Trust weekly Patient Safety Meeting when nominated by the Division for wider review and action.

8.3 A quarterly report is presented to the People and Wellbeing Committee by the Equality and Diversity Lead outlining:

i. The number of reported discriminatory incidents against staff

ii. Any subsequent actions taken by the Trust against offenders

iii. Any actions taken to prevent a re-occurrence

iv. How this policy was invoked to manage any incident of discriminatory behaviour, the actions taken, and the outcome

v. Any suggestions from staff for improvement to encourage staff to report any incidents (You Said; We Did)

8.4 The annual report will be presented to the Trust Board via the People and Wellbeing Committee, detailing the work that has been carried out over the previous year, and identifying what actions the Equality and Diversity lead will employ to reduce incidents for the forthcoming year.

8.5 As a new policy, the guidance, process, effectiveness, impact and outcome will be reviewed, evaluated and updated as appropriate to consider the views of the service users.

9. Further Information

Anti-racist Framework NHSE 2021

Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9 (see DMS)

Security Policy - RM48 (see DMS)

Supporting Staff Policy - RM49 (see DMS)

Incident Reporting and Management Policy - RM2 (see DMS)

Safeguarding Policy - M3 (see DMS)

Tier 4 CAMHS Policies (see DMS)

Looked After Children Policy - M65 (see DMS)

Prevent Policy – RM19 (see DMS)

Equality, Diversity and Human Rights Policy – E1 (see DMS)

Appendix A: Procedure to follow for racist, homophobic, prejudiced or discriminatory behaviour by parents / carers / legal guardians

Non-Physical / Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
A **first (only) incident of discriminatory behaviour which is believed to have been unintended and did not cause harm**	**Stage 1: Local Resolution**	Ward Manager or Nurse in Charge Lead Consultant Staff member involved if feel safe and able to do so Expert Review Panel	a) Talk to the parent in a quiet area away from the patient's bedside to reduce any distress to the patient. b) Be clear with the parent the nature of the unacceptable behaviour that has been witnessed, as a parent may not appreciate that Trust staff find such behaviour unacceptable. Explain and inform the parent that their behaviour, although considered not to be intentional, is considered to be discriminatory. Inform that the Trust has zero tolerance of behaviour considered to be discriminatory and that there must be no repeat of the behaviour. It is reasonable to expect that most individuals will be shocked and concerned to learn that their behaviour is considered discriminatory if it was not intended and that an immediate unreserved apology will be proffered with assurance that there will be no repeat of the behaviour. c) An Expert Review Panel should be convened for the next working day, by the Matron / Team Leader, to review the incident and determine whether the incident should be managed in line with Stage 3. The response of the parent to the initial discussion will be considered. If the parent does not apologise or appear to take the matter seriously this should be escalated to Stage 3 as is indicative of intentional discriminatory behaviour d) Where Stage 1 management is agreed by the Expert Review panel, this should include proactive educational support to the family e) Inform the parent of the plan to go forward including that any repeat of such behaviour will result in a sanction	**Agreed verbal plan to go forward** (documented in health record) **Expert Review Panel convened to review appropriate management / Stage**

			f) Fully document the conversations with the parent in the child's health record in line with Section 6 l) Complete a Ulysses incident form.	
An incident of overt or subtle microaggressive racist, homophobic, prejudiced or discriminatory behaviour occurs **Or** **A subsequent incident of discriminatory behaviour believed to be unintentional and did not cause harm following Stage 1 actions**	**Stage 3: Meeting**	Matron / Service Manager Lead Consultant	a) Formal face to face meeting with the parent where the child is in or attending the Trust, or formal telephone meeting where the incident has been via telephone or written. Talk to the parent in a quiet area away from the patient's bedside to reduce any distress to the patient. b) Inform the parent of the incident and tell them that the behaviour is unacceptable and discriminatory, will not be tolerated and must stop c) Inform the parent that they will now receive a formal written warning (see template letter in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy - RM9** (see DMS). Be clear that the Trust will not tolerate this behaviour and that further incidents may result in restrictions on visiting or exclusion. d) Escalate the behaviour to the Divisional Senior Leadership Team (Associate Medical Director; Associate Chief Operating Officer; Associate Chief Nurse) e) Fully document the meeting in the child's health record f) Complete a referral to the Safeguarding Team and inform the parent	**Formal written warning**
Any subsequent incident of racist, homophobic, prejudiced or discriminatory behaviour occurs	**Stage 5: Excluded from the hospital**	**In hours:** Chief Nurse / Director of Nursing Medical Director LSMS / Security **Out of hours:** First On Call Manager	a) Parent asked to leave the hospital by the Chief Nurse / Director of Nursing and the Medical Director, or a member of the senior team on duty or on call out of hours. A member of the Security Team should be in close proximity though not necessarily in direct proximity. b) Ensure that safety is maintained at all times. If behaviour becomes violent or there is a threat of violence or safety is felt to be compromised call Security on 3181 main hospital, or 2004 Catkin, and call the Police on 999	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

		Night Matron Security Registrar (if available) Inform the second on call manager	c) Issue a letter of exclusion to the parent (see template letter in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS). d) If the parent refuses to leave the hospital, the Security Team will escort the parent from the hospital e) Escalate the situation to the Executive team / second on call manager f) The parent is not allowed to return to the hospital until an Emergency Planning Meeting has been held on the next working day in line with **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) to devise an agreed plan. (If, for the patient's benefit, access is urgently required prior to the Emergency Planning Meeting being held, this must be agreed by the Executive Lead, LSMS and Security in hours, and the Site Co-ordinator, Second On Call Manager and Security out of hours)	

Appendix B: Procedure to follow for racist, homophobic, prejudiced or discriminatory behaviour by other visitors

Non-Physical / Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
A **first (only) incident of discriminatory behaviour which is believed to have been unintended and did not cause harm** **Or** **A subsequent incident of discriminatory behaviour believed to be unintentional and did not cause harm following Stage 1 actions**	**Stage 1: Local Resolution**	Ward Manager or Nurse in Charge Lead Consultant Staff member involved if feel safe and able to do so Expert Review Panel	a) Talk to the parent in a quiet area away from the patient's bedside to reduce any distress to the patient. b) Be clear with the parent the nature of the unacceptable behaviour that has been witnessed, as a parent may not appreciate that Trust staff find such behaviour unacceptable. Explain and inform the parent that their behaviour, although considered not to be intentional, is considered to be discriminatory. Inform that the Trust has zero tolerance of behaviour considered to be discriminatory and that there must be no repeat of the behaviour. It is reasonable to expect that most individuals will be shocked and concerned to learn that their behaviour is considered discriminatory if it was not intended and that an immediate unreserved apology will be proffered with assurance that there will be no repeat of the behaviour. c) An Expert Review Panel should be convened for the next working day, by the Matron / Team Leader, to review the incident and determine whether the incident should be managed in line with Stage 3. The response of the parent to the initial discussion will be considered. If the parent does not apologise or appear to take the matter seriously this should be escalated to Stage 3 as is indicative of intentional discriminatory behaviour d) Where Stage 1 management is agreed by the Expert Review panel, this should include proactive educational support to the family e) Inform the child's parent of the incident and that the visitor will be excluded from visiting if there are any further incidents	**Agreed verbal plan to go forward** (documented in health record) **Expert Review Panel convened to review appropriate management / Stage**

			f) Fully document the conversations with the parent in the child's health record in line with Section 6 l) Complete a Ulysses incident form.	
An incident of overt or subtle microaggressive racist, homophobic, prejudiced or discriminatory behaviour occurs	**Stage 5: Excluded from the hospital**	**In hours:** Associate Chief Nurse / Head of Nursing Associate Medical Director LSMS / Security **Out of hours:** First On Call Manager Night Matron Security Registrar (if available) Inform the second on call manager	a) Visitor asked to leave the hospital by the Associate Chief Nurse and the Associate Medical Director or Associate Chief Operating Officer, or a member of the senior team on duty or on call out of hours. A member of the Security Team should be in close proximity though not necessarily in direct proximity. b) Ensure that safety is maintained at all times. If behaviour becomes violent or there is a threat of violence or safety is felt to be compromised call Security on 3181 main hospital, or 2004 Catkin, and call the Police on 999 c) Send a letter of exclusion to the individual (see template letter in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy - RM9** (see DMS)) d) If the visitor refuses to leave the hospital, the Security Team will escort the visitor from the hospital e) Escalate the situation to the Executive team / second on call manager f) The visitor is not allowed to return to the hospital until an Emergency Planning Meeting has been held on the next working day in line with **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) to devise an agreed plan. (If, for the patient's benefit, access is urgently required prior to the Emergency Planning Meeting being held, this must be agreed by the Executive Lead, LSMS and Security in hours, and the Site Co-ordinator, Second On Call Manager and Security out of hours)	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix C: Procedure to follow for violent behaviour by any visitor including parents

Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An incident of violent behaviour occurs	**Stage 5: Excluded from the hospital**	**In hours:** Chief Nurse / Director of Nursing Medical Director LSMS / Security **Out of hours:** First On Call Manager Night Matron Security Registrar (if available) Inform the second on call manager	a) Parent / visitor asked to leave the hospital by the Chief Nurse / Director of Nursing and the Medical Director, or a member of the senior team on duty or on call out of hours. A member of the Security Team should be in direct proximity. b) Ensure that safety is maintained at all times. If behaviour becomes violent again or there is a threat of violence or safety is felt to be compromised call for additional Security assistance on 3181 main hospital, or 2004 Catkin, and call the Police on 999 c) Send a letter of exclusion to the individual (see template letter in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy - RM9** (see DMS) d) If the parent / visitor refuses to leave the hospital, the Security Team will escort the parent / visitor from the hospital e) Escalate the situation to the Executive team / second on call manager f) The parent / visitor is not allowed to return to the hospital until an Emergency Planning Meeting has been held on the next working day in line with **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) to devise an agreed plan. (If, for the patient's benefit, access is urgently required prior to the Emergency Planning Meeting being held, this must be agreed by the Executive Lead, LSMS and Security in hours, and the Site Co-ordinator, Second On Call Manager and Security out of hours)	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix D: Procedure to follow for threatening or offensive language over the telephone by any individual including parents

Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An incident of threatening or offensive language occurs for example a threat of violence; racist, homophobic, prejudiced or malicious language	**Stage 5: Inform the Police** **Excluded from the hospital**	Chief Nurse / Director of Nursing / Medical Director / Chief Operating Officer	a) Tell the parent / caller you are going to terminate the telephone call and do so immediately. b) Inform your line manager immediately who will escalate to the Divisional Management Team, the Safeguarding Team, LSMS and the Police to report the incident c) Call the Police on 999 to report the incident d) Send a letter of exclusion to the individual. This will advise that in the event that their child needs to attend the hospital for a planned appointment during the period of exclusion, another responsible adult should accompany the child. Where a child needs to attend the Emergency Department (ED), and the individual excluded is the adult responsible for the child at that time, then in the interests of patient safety the individual is allowed on the premises to escort the child to ED (see template letter in **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) e) Escalate the situation to the Executive team / second on call manager f) Invoke an Emergency Planning Meeting for the next working day in line with **Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy – RM9** (see DMS) to devise an agreed plan.	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this form		
Policy Name	RM70 - Zero Tolerance of Racist, Homophobic, Prejudiced or Discriminatory Behaviour	
Policy Overview	Discriminatory behaviour towards our staff will not be tolerated at Alder Hey. This policy provides all staff with support and guidance in the management of any incident perceived to be racist, homophobic, prejudiced or discriminatory in any way exhibited by a parent, visitor or patient This is a new policy however the principles and Zero Tolerance Process outlined are in line with the overarching RM9 – Preventing & Managing Violence & Aggression at Work, Zero Tolerance Process & Protecting Lone Worker Policy	
Relevant Changes (if any)	NA	
Equality Relevance Select LOW, MEDIUM or HIGH	HIGH	
If the policy is LOW relevance, you **MUST** state the reasons here.	Click here to enter text.	
Form completed on:	Date: 03/02/2022	
Form completed by:	Name: Pauline Brown	Job Title: Director of Nursing

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections		
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy and include details of how they may be impacted. (use **Equality Relevance** to assess the impact on each protected characteristic)	Protected Characteristic	Mitigation
	Age ☑ How: 1. This policy considers discriminatory behaviour which may be exhibited by children and young people who are receiving care and treatment from Alder Hey, potential causal factors for the behaviour, and guidance on action to be taken 2. This policy considers and manages any potential	The policy provides clear guidance, best interest considerations, roles and responsibilities to ensure the continued safety of all children and young people requiring care and treatment whilst ensuring the safety of staff and a zero tolerance of discriminatory behaviour. This includes education, support, safeguarding, and a multi-agency approach. This may include a review panel review

	source of discriminatory behaviour which includes discrimination on the basis of age exhibited by parents, visitors or patients	led by the Chief Nurse or Medical Director; any decision to discharge, delay, postpone or withhold treatment from a patient due to discriminatory behaviour, must have clearly planned onward arrangements and timescales for future review and the Chief Executive must be informed of the decision, action and onward plan. 2. Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of age will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Disability ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of disability exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of disability will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Gender reassignment ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of gender identity exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of gender identity will: • Be believed • Be listened to • Be taken extremely seriously on every occasion

		• Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Marriage & Civil Partnership ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of sexual orientation exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of sexual orientation will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Pregnancy or Maternity ☐ How: Click here to enter text.	
	Race ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of race exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of race will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Religion or Belief ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of religion exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of religion or belief will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations

		All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Sex ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of gender identity exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of gender will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Sexual Orientation ☑ How: This policy considers and manages any potential source of discriminatory behaviour which includes discrimination on the basis of sexual orientation exhibited by parents, visitors or patients	Staff who raise a concern that they have experienced or witnessed discriminatory behaviour on the basis of sexual orientation will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
	Human Rights (FREDA principles) ☑ How: The human rights of staff to be able to work in a safe environment, where discriminatory behaviour is not tolerated, is a core and fundamental principle of the policy	Staff who raise a concern that their human rights have been contravened and they have experienced or witnessed discriminatory behaviour will: • Be believed • Be listened to • Be taken extremely seriously on every occasion • Be supported by the Trust and supported to report to the Police and / or support organisations All incidents will be managed in line with the Zero Tolerance Process outlined in the policy
Equality Information & Gaps	Zero Tolerance posters under development. Visitors and Relatives Charter displayed in all wards / departments. Policy	

What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	will be launched with a clear implementation plan and training plan for all staff	
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups? See **Gunning Principles** for public consultation requirements. **How has consultation influenced the policy?**	This policy is the result of 8 months of consultation with a large number and diverse group of staff. The policy has evolved based on feedback to: • Include discriminatory behaviour exhibited by patients – policy originally in regard to parents and visitors • Include Stage 1 of the Zero Tolerance Process – policy originally escalated straight to at least Stage 3 • Recommend an Expert Review Panel is set up in some circumstances to support staff and review most appropriate action	
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	This policy is linked to, and supports, a number of policies including Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy - RM9; Safeguarding Procedures - M3; Supporting Staff Policy - RM49; Incident Reporting and Management Policy - RM2; Tier 4 CAMHS Policies; Looked After Children Policy - M65; Prevent Policy – RM19 This policy does not have any adverse effect on any other policy or scheme	
Public Sector Equality Duty Include a summary of how each of the PSED requirements have been considered in order to demonstrate compliance with the Act.	a) Eliminate discrimination, harassment, victimisation etc The requirements have been considered and met in that the purpose of this policy is to promote harmony, manage any incidents of discriminatory behaviour and support staff throughout	
	b) Advance equality of opportunity Equal opportunity; fair, consistent and equitable management plan	
	c) Foster good relations Policy centred around a safe place to work for all staff that does not tolerate discriminatory behaviour. Staff will be believed, listened to, supported and action of some form will be taken in every incident. Proactive approach to education and support for patients, parents and visitors where unintentional micro-behaviours displayed to promote social and racial harmony	
	Has the Public Sector Equality Duty been met? Yes ☒ No ☐	
Monitoring Include details of how the equality impact will be monitored.	As a new policy, the guidance, process, effectiveness, impact and outcome will be reviewed, evaluated and updated as appropriate to consider the views of the service users. This will include review with the Trust BAME, LGBTQIA+ and Disability Networks and CYP Forum	
Review of Equality Analysis (if indicated)	Rationale for review: NA Version 1	
	Changes made: Click here to enter text.	Reason for change: Click here to enter text.

If **MEDIUM** or **HIGH r**elevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Pauline Brown	Job title: Director of Nursing
Approval Committee:	Clinical Quality Steering Group	Date approved: 08/02/2022
Ratification Committee:	People and Wellbeing Committee	Date ratified: 15/02/2022
	Safety and Quality Assurance Committee	Date ratified: 16/02/2022
Person to Review Equality Analysis:	Name: Pauline Brown	Review Date: 16/02/2023
Comments:	Click here to enter text.	